FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			(X3) DATE SURVEY COMPLETED	
	135090	B. WI	/G		08/0	2/2006
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poorly - has been had apparent reason *2/21/06 at 3:30 am UTIfoley catheter [with] much white set *2/21/07 at 3:15 pm #2]. She was being cursing. Chin is quividenies being cold. Fand applied O2. SA this were 63%. SAT per minute], [increas she relaxed SATS of to 96% on 4L. Turne [blood pressure] 13: [respirations] 24, T Fahrenheit]. Noted lung only. Continues [telephone call] to [pt *2/21/06 at 3:50 pm to [hospital] ER for each oxygen sat Information provided documented the foll *"3/02/06- Urine poswith Zosyn changed	eard x3 screaming & crying for" 1 - "Cont. [continues] ABT for patent of clear yellow urine ediment" 1 - "Called to [check] [resident taken to room. Yelling & vering [illegible word] she Put to bed [with] mechanical lift TS [saturation] previous to S 71% on O2 at 2L/min [liters sed] O2 to 3L [liters] but when dropped back to 68%O2 uped O2 to 3 1/2L/min. BP 2/80, P [pulse] 119, R [temperature] 101.9 [degrees Expirational wheezing in [right] is to deny painT.C. ohysician] per pager." - "Received order to transfer evaluation." cal, dated 2/22/06, sident was admitted to the nary tract infection and urations. d by the facility on 7/31/06 owing: sitive for enterococcus treated to Augmentin. Repeat UA	F	315			
~~5/U3/Ub- Started a	nublotics for UTI this am.					
	ROVIDER OR SUPPLIER S CARE AT SHAW M SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa poorly - has been had apparent reason *2/21/06 at 3:30 am UTIfoley catheter [with] much white se *2/21/07 at 3:15 pm #2]. She was being cursing. Chin is quived applied O2. SA this were 63%. SAT per minute], [increases he relaxed SATS of to 96% on 4L. Turner [blood pressure] 13: [respirations] 24, T Fahrenheit]. Noted lung only. Continues [telephone call] to [pr *2/21/06 at 3:50 pm to [hospital] ER for each of the respiration provided documented the responsible documented the foll *"3/02/06- Urine possible with Zosyn changed order in one week."	TOTAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ROVIDER OR SUPPLIER S CARE AT SHAW MT Summary STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 55 poorly - has been heard x3 screaming & crying for no apparent reason" *2/21/06 at 3:30 am - "Cont. [continues] ABT for UTIfoley catheter patent of clear yellow urine [with] much white sediment" *2/21/07 at 3:15 pm - "Called to [check] [resident #2]. She was being taken to room. Yelling & cursing. Chin is quivering [illegible word] she denies being cold. Put to bed [with] mechanical lift and applied O2. SATS [saturation] previous to this were 63%. SATS 71% on O2 at 2L/min [liters per minute], [increased] O2 to 31. [liters] but when she relaxed SATS dropped back to 68%O2 up to 96% on 4L. Turned O2 to 3 1/2L/min. 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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOU	LD BE	(X5) COMPLETION DATE
F 315	Urine clear amber v	vith small blood clots."	F3	15				
	dated July 2006, do in regards to cathet	citulation [RECAP] orders, cumented the following orders er care:			·			
	*"[change] S/P cath French next time th [with] each catheter	q [each] month, place 18 en 20 French after that [and] change irrigate cath [with] neters] GU irrigation [with]	A					
	the information con RECAP but did not	et, dated July 2006, addressed tained on the resident's address specific issues atheter care or prevention of ons.	•					
	resident was observed to wash her hands a beginning the reside observed to remove observed to change continuing catheter gloves, the LN used.	eximately 11:45 am, the ved during the provision of care. The LN was observed and apply gloves before ent's care. The LN was the old dressing and was not into clean gloves before care. Wearing contaminated in a pre-moistened piece of						
	cleaning around the observed to wipe to gauze as opposed to used the gauze to discretion of the gauze repeated the dabbir	estoma site. While estoma site, the LN was wards the stoma site with her to wiping away from it. The LN lab around the stoma site in a er folding the contaminated e into her gloved hand, she ng motion with a clean portion of gauze, again wiping towards						

PRINTED: 08/16/2006 FORM APPROVED OMB NO. 0938-0391 PARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY NTERS FOR MEDICARE & MEDICAID SERVICES COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA EMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING 08/02/2006 PLAN OF CORRECTION B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 135090 909 RESERVE ST WE OF PROVIDER OR SUPPLIER BOISE, ID 83712 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION ARQUIS CARE AT SHAW MT (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID REFIX TAG F 315 Continued From page 57 F 315 the stoma site. When the LN had completed cleansing the site, the LN discarded the contaminated gauze and picked up the clean dressing with her contaminated glove. The LN then applied the dressing to the resident's stoma site. The LN was not observed to cleanse the catheter tubing before applying the clean dressing. According to Nursing Interventions & Clinical Skills (Elkin, Perry, Potter 2000, p. 829), when caring for a suprapubic catheter care and to prevent infection, an LN should: *"Remove old dressing and place dressing and gloves in bag." *"Put on sterile gloves, assess insertion site and patency of catheter." *Maintaining sterility, clean site by swabbing in circular motion starting closest to the catheter site and continuing in outward widening circles for approximately 2 inches (5 cm [centimeters])..." The LN is instructed to perform this step as many times as needed to cleanse the site. The authors note this procedure "follows principle of sterile technique to move from area of least contamination to area of most contamination....Take one gauze pad moistened in antiseptic solution and cleanse catheter from proximal to distal." An interview was conducted with the DON and three RCMs on 7/27/06 at 11:55 am regarding resident #2's care plan and the prevention of UTIs. The DON noted that urinary tract infections were common in residents who were catheterized

	OF DEFICIENCIES F*CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		JRVEY TED
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F 315	regarding preventarisk. The DON and specific care plan prevention of UTIs documented on the sheet. The facility failed to resident who had pyelonephritis, idea repeat UTIs and infurther infections, effective infection suprapubic cathet infection. At the timo measures in plinfections. 2. Resident # 1 w facility on 10/19/0 on 5/23/06 with didecubitus ulcer, ocirrhosis, diabetes Staphylococcus A chronic anemia, a resident had a sumeurogenic bladd. The most recent I the resident was the bathing, toileting, The care plan, da catheter in proble plan documented catheter and the second in	s what the facility had in place ative measures for residents at a RCMs acknowledged the discussed did not address the s. They noted catheter care was e resident's monthly treatment of appropriately assess a history of UTIs and notify she was at high risk for an interpretable and the practice control measures during er care to reduce the risk of the of the survey, the facility had acce to prevent urinary tract as originally admitted to the fand most recently readmitted agnoses including Quadriplegia, steomyelitis, pancytopenia, and chronic leukopenia. The prapubic catheter due to a	F 315			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
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F 315	prevention, and did The physician REC documented the fol resident's catheter: *5/23/06 "Supra Pu shift DX [diagnosis] *5/23/06 "Change S French w/30 cc ball The treatment shee documented "Supe Shift" and "Change French W/30 CC B Information provide revealed the followitract infections: *10/19/05 The reside following hospitalization, the home. *12/07/05 Temperate Fahrenheit], bloody catheter. Started or with culture and set revealed Escherich *12/22/05 UA obtain trauma with increas revealed Pseudome.	TI, goals, and interventions for not address catheter care. AP orders, dated July 2006, lowing orders in regards to the bic Cath[eter] care q [every]: Neurogenic bladder." Supra Pubic Cath Q month 20 loon." et, dated July 2006, r [sic] Pubic Cath Care Q Super [sic] Pubic Q Month 20 alloon." d by the facility on 7/31/06 ng history related to urinary lent was admitted to the facility ation for urosepsis. Prior to the resident had been living at ture of 100 [degrees drainage from suprapubic of Macrobid and urinalysis (UA) insitivity obtained. The results lia coli (E-coli). The due to "SP [suprapubic] and due	F	315			
	Croroc ri ci pinot	ory arra projection of action					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION . DATE
F 315	than] 1030, 1+ protoccult blood, 3+ leu 5-10 RBC's [red bloblood cells], many is Impression: Acute seither from leg wou. A physician's note, resident, "was hosp a urinary tract infect. The resident was operi care on 7/25/06. The LN washed he before cleaning and pressure ulcer on the LN was not obhands or change he care for the stage I'resident's left ischiud ocumentation, the isolation precaution stage IV pressure ucovered the wound reached into her pogloves to pull out a pen. The LN was oback into her pocked contaminated glove care, the LN procederepositioning the rebowel movement acute. The LN was residing herse gloves before they	ith specific gravity > [greater einuria, trace ketones, 3+ kocyte esterase, + nitrites, and cells], 25-50 WBC [white pacteria, moderate yeast. sepsissuspect early sepsis, and or from UTI." dated 6/23/06, revealed the bitalized on 5/17/06-5/23/06 for tion with candida albicans." bserved during wound and at approximately 11:10 am. In hands and donned gloves a covering the stage II he resident's right ischium. Served to wash or sanitize her er gloves before proceeding to V pressure ulcer on the	F3	15			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I A. BÜ		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		135090	B. WI	NG_		08/6	02/2006	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 315	contact with the top bed. The CNA and they would change resident up for lunc completing peri cardicean clothing, staff resident directly on of the air bed with he contact with the cordinated with the flow and RCMs acron the residents who were address what the faprevention measured DON and RCMs acron the residents with facility was taking to stated they used a litimes to prevent the the floor and becomfollowing facility procease. After the intervention presented the survein handwritten list that information: Vitamin Suprapubic catheter who Minocin 100 milligration the resident's physician the resident had been supposed with the contact with the cordinated wit	cover of the resident's air LN wiped the area and noted the cover after getting the h in about an hour or so. After e and dressing the resident in were observed to place the top of the contaminated area is clean clothing in direct utaminated surface. Inducted with the DON and 7/06 at 11:55 am regarding is care plans and the As stated above, the DON act infections were common in catheterized but did not cility had in place regarding is for residents at risk. The knowledged the specific care not address the prevention of atheter care was documented outhly treatment sheet. When not preventative measures the in UTIs for resident #1, staff ag bag on the resident at catheter tubing from touching ing contaminated as well as tocol for suprapubic catheter view was concluded, a RCM	F	315				

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	-	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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ulcer. The facility failed to resident who had a identify he was at himplement a care prinfections. Facility s control during woun with known MRSA i resulted in harm to hospitalized in May infection. At the time no measures in placinfections. 3. Resident #8 was facility on 1/26/1995 with diagnoses inclusionally with diagnoses inclusionally with the care plan, date. The most recent que 5/26/06, documente impaired cognition, care and had a supertreasure of the care plan, date.	appropriately assess a history of UTIs and urosepsis, igh risk for repeat UTIs and lan to prevent further taff practiced poor infection d and peri care on a resident infection. This failed practice the resident who was 2006 with a urinary tract of the survey, the facility had be to prevent urinary tract originally admitted to the facility admitted on 3/25/04, adding paraplegia, rogenic bladder, UTI, status is and cellulitis of the arterly assessment, dated at the resident had severely was totally dependent for all rapubic catheter in place.	F	315			
plan documented the catheter and the size balloon. The care place resident's risk for U prevention, and did The physician's REG documented "Supra	e resident had a suprapubic e of the catheter and the an did not address the TI, goals, and interventions for not address catheter care. CAP, dated July 2006, pubic cath care q shift" and					
	ROVIDER OR SUPPLIER S CARE AT SHAW M SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa ulcer. The facility failed to resident who had a identify he was at hi implement a care p infections. Facility s control during woun with known MRSA i resulted in harm to hospitalized in May infection. At the time no measures in place infections. 3. Resident #8 was facility on 1/26/1996 with diagnoses inclused in the serior of the control of the co	ROVIDER OR SUPPLIER S CARE AT SHAW MT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 62 ulcer. The facility failed to appropriately assess a resident who had a history of UTIs and urosepsis, identify he was at high risk for repeat UTIs and implement a care plan to prevent further infections. Facility staff practiced poor infection control during wound and peri care on a resident with known MRSA infection. This failed practice resulted in harm to the resident who was hospitalized in May 2006 with a urinary tract infection. At the time of the survey, the facility had no measures in place to prevent urinary tract infections. 3. Resident #8 was originally admitted to the facility on 1/26/1995, and readmitted on 3/25/04, with diagnoses including paraplegia, schizophrenia, neurogenic bladder, UTI, status post venous thrombosis and cellulitis of the	ROVIDER OR SUPPLIER S CARE AT SHAW MT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 62 ulcer. The facility failed to appropriately assess a resident who had a history of UTIs and urosepsis, identify he was at high risk for repeat UTIs and implement a care plan to prevent further infections. Facility staff practiced poor infection control during wound and peri care on a resident with known MRSA infection. 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F 315	[French]/30CC Balka Neurogenic Bladder month]." An order, of "7/19/06 Ampicillin BID [twice a day] x Results of a urine of documented the preorganisms: Pseudo and Enterococcus Facults of a urine of documented the preorganisms: Pseudo and Enterococcus Facults of a urine of documented the preorganisms: Pseudo Enterococcus Facults of a urine of documented the preorganisms: Pseudo Enterococcus Facults of a urine of documented the preorganisms: Pseudo Enterococcus Facults of a urine of documented the preorganisms: Pseudo Enterococcus Facults of the dressings from a case on the resident's bethe table or providing supplies and the contact of the wound and placed dressings on the own hand with the contact of the wound and follow up of UT indwelling with the light of the preorganisms: The incident of the preorganisms of th	con DX [diagnosis]: (Change Q MO [every dated 7/19/06, documented, 500 mg [one] po [by mouth] 14 days. Dx [diagnosis] UTI." (ulture, dated 6/29/06, esence of the following monas Aeruginosa, MRSA, esence of the following monas Aeruginosa and ealis. (ulture, dated 7/13/06, esence of the following monas Aeruginosa and ealis. (am, the surveyor observed a sing to a pressure sore on the The LN obtained the clean rt, placed the clean supplies did table without cleaning g a barrier between the clean entaminated over bed table. Oved the dressing, cleansed eat the contaminated erbed table. Then, using the minated glove, adjusted the minated glove, adjusted the tesses urinary tract infections is as follows: "A long term >2 to 4 weeks) increases the symptomatic UTI and ence of bacteremia is 40 viduals with a long term than in those without	F3	315			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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	lead the facility to clis performed consis in accordance with a re-evaluate the tech perineal hygiene an should demonstrate infection control pra and associated draithe resident and cat minimize bacterial in bladder; Assess for a fluid management assessed needs." The facility failed to UTIs, develop care in measures and democontrol practices during dementia. At the time had a Foley catheter discontinued on 5/1/nursing notes. An MDS, dated 5/9/0 was severely impaired dependent on staff fuse and that she warrine. An "Assessment for dated 4/28/06, docur" Bladder Continence	catherized individual should neck whether perineal hygiene tently to remove fecal soiling accepted practicesto iniques being used for d catheter carethe facility that they: Employ standard ctices in managing catheters nage system; Strive to keep theter clean of feces to inigration into the urethra and or fluid needs and implement programbased on those identify residents at risk for plans addressing preventative onstrate appropriate infection ring wound and catheter care.	F	315			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	2) MULTIPLE CONSTRUCTION (X3) DATE S BUILDING COMPLE			
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F 315	noted the resident has been inserted on 4/. "Evaluation", "Histor Management" section blank. The care plan was radmission date of 4 addressed toileting and documented the bowel and urine and place. One portion of undated documented catheter tubing" and an "Assessment Sudocumented "Res[id [and] is dependent to plan." An interview was con RCMs on 7/27/06 and acknowledged a bladeen completed on was removed on 5/2 would have to look anotes as that was wand they should have "[the resident] residemented" She adnot assess the voiding the section of the s	introl)" was marked. The form had a Foley catheter that had 23/06. The "Symptoms", ry", and "Plan for ons of the form were left on the dated but documented an /28/06. The care plan in problem 1, "ADL/REHAB" is resident was incontinent of thad a Foley catheter in of the care plan that was ed the resident "pulls on that a "UTI." Immary", dated 5/11/06, dent] toilets [with] assist of 2 for peri care, proceed to care onducted with the DON and 3 to 12:35 pm. The DON and 4 the resident after the catheter at OT (Occupational Therapy) in their scope of practice assessed her. She stated, ists a lot, [the resident] is very cknowledged the facility diding patterns of the resident.	F	315			
	3:10 pm , regarding assessment. She st didn't re-assess after	viewed again on 7/27/06 at an updated bladder ated, "We did assess, we just or the Foley was removed." esident was incontinent due to		·			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ι΄ ΄	ULTIPLE CONSTRUCTION LDING	(X3) DATE S COMPLI	
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F 315	dementia and state everyone, they would have everyone, they would not excluded a service bladder function to resident was not recatheter was remove admitted to the facil documentation on the referencing the resident everyone incontinence, voiding in reference to incontinence, voiding in reference to incontinent was not can toileting program for tract infections related the resident was as MDS of 5/9/06 and "CNA Flow Sheet" incontinent at the time. 5. Resident #7 was 7/21/06 with the diated tongue cancer, hypothesis in the program of the	d that if the facility toileted Idn't have time for other cares. Insure a resident was diregarding urinary ure she received the sito restore or improve normal the extent possible. The cassessed after her Foley and 3 days after she was ity. The facility had no the bladder assessment dent's prior history of a patterns, medication review notinence, patterns of fluid aprehensive assessment at to urinary incontinence. The replanned for a specific or the prevention of urinary ed to incontinence issues. It is sessed as incontinent per the documentation from the July indicated she was the of the survey. Inadmitted to the facility on gnoses of squamous cell on pneumonia. In Assessment', dated and under did under did under did under did under fractured hip. Dr [doctor]	F3	115		

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S COMPL	
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F 315	Resident #7's curre the resident had a control of the resident had	ontinue Foley per [physician appointment" Int care plan documented that commode at his bedside. If low sheets for July e resident used the bed side ng. If pm, resident #7 was cated with the motion of his that he used his bed side it movements. If movements am, the DON indicated that mitted with a Foley catheter re why it was in place but et the surveyor know. Several a provided the surveyor with a	F3	15		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	
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F 323 SS=E	The facility must enervironment remains is possible. This REQUIREMED by: Based on observatifacility did not ensure facility did not ensure free of accident has were found in 1 of thall and in the soiled Skin tear hazards where the facility of the soiled skin tear hazards who used the shown in to the soiled utility. 1. Unlocked Chemical and the powho used the shown in to the soiled utility. 2. Unlocked Chemical and the powho used the shown in the door and cleaner was on a simmediately locked out of sight. 3. The soiled linent approximately 3:46 and the cupboard upottle of bleach that and a 1/2 full bottle of bleach that and a 1/2 full bottle.	nsure that the resident ns as free of accident hazards NT is not met as evidenced ion it was determined the re the environment remained zards. Unlocked chemicals 2 shower rooms on the 200 ed utility room on the 100 hall were observed in 4 of 4 shower was at risk for a fall when he on an air bed with one side cted 1 of 11 sample residents of the common or who may wander by room. Findings include:	F 3	223	Corrective Action: 1. All chemicals in the shower and soiled utility rooms were platocked cabinets. 2. The tile in the 200 Hall showe has been repaired. 3. The edges of the shower room have been repaired. 4. Resident #3 has been informather safety hazards related to the use of side rails while utilize specialty air bed and the manufact recommendations. He understand without the use of side rails he slide from mattress and be injured has accepted the use of side rails in bed on a specialty mattress. Identification: All residents are identified as poth being affected. Systemic Changes: 1. The maintenance, housekeepinursing staff has been instreaming staff to be inservict the chemicals locked in a scabinet. 2. Maintenance will complete environmental rounds to identify complete repairs and assure chemical storage is maintained. 3. Nursing staff to be inservictly standard practice and manufare recommendations to have side to while resident is in bed utilispecialty air mattress for safety. 4. A nursing order to the reaminest Administration Record to "Monitor Side Rails to be uptimes while resident is in bed bed/mattress each shift" Continued on p. 70	r room n doors med of he non- zing a cturer's ds that he could red. He s while mentially fing and herviced ge of he of he covered weekly fy and proper ced on he cturers' rails up hizing a sident's he call	

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	2. Skin Tear Hazard a. During the environment of the first shower roomed the 200 hall, brown the room. The brown the room. The brown the and calf level, edges and presenter residents entering the Four of 4 shower roomed tear hazards on the Chunks of wood was the ankle and calf led damaged and scarre from the floor. These hazards to residents either on foot or via doors contained shat The maintenance mindicated he would to the series of the congue cancer, hypodaspiration, stage III premur, and aspiration A "physical restraint/ assessment/consent documented, "Restraint/ assessment/ assessment	onmental inspection on lately 3:25 pm, skin tear vered in 4 of 4 shower rooms. From the nurses' station can tile was observed on a she shower stall from the rest oken tile was at approximately contained sharp, jagged d a skin tear hazard to be shower. The facility had skin outside of the entrance doors is missing at approximately vel and the doors were also approximately a feet up a areas presented skin tear is entering the shower rooms wheel chair. The edges of the areas with wood slivers, an was present and he aske care of the problem.	F	323	Monitor: 1. Maintenance and Admin monitor environmental round: compliance weekly. 2. DNS to audit resident and Administration Record (TAR) sutilization compliance on using air beds/mattresses with Quality Assurance Committee.	Treatment for side rail residents' weekly and	9/2/2006

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F 323	observed to be lyin up and the right side continued for ten makes made aware of acknowledged that indicated that it shows for the reside recommendation for provided a copy. The Gaymar Plexity information on page	o am resident #7 was g in bed with his left side rail le rail down. This observation ninutes. At this time the DNS of the observation. The DNS the side rail was down and build be up because of his air me the surveyor asked the nts air mattress manufacturer's or side rails and the DNS	F	323			•	
F 325 SS=D	The facility did not provided with an enhazards as possible 483.25(i)(1) NUTR Based on a reside assessment, the faresident maintains nutritional status, slevels, unless the indemonstrates that This REQUIREMED by: Based on observa		F3	25	Corrective Action: 1. Resident #1 refers to the Correction for F-272, F-279, and Resident number 1 did have weights taken and were in the riclinical record along wit corresponding weight/nutrition meeting assessments and notes in the vital sign and weight set the resident's clinical record. 2. A significant change in Minimum Data Set (MDS) completed to fully reflect the recurrent medical, functional, physical plan will be revised according correspond to the MDS assedata. Continued on p. 72	d F-309. weekly esidents h the at risk located ection of status will be esident's sical and nt's care ngly to		

STATEMENT	OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` ′		PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
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MAKO	*			В	PROVIDER'S PLAN OF CORRECT	TION	(X5)
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F 325	of 11 sampled resicomplete assessmaccurate documen weight loss of 12 p. The findings included Resident #3 was a diagnoses which in hematoma of left land history of peptresident's weight work (pounds) and she the admission MI resident was severed dependent in all A extensive assistant The Nutritional States documented that the summary documented that the summary documented the fat risk R/T [related short term goals in meals, no s/s [sig dehydration, no sid documented appropriate of the program], (4) RD finish food and flut food flut food and flut food flut food flut food flut flut food flut flut flut flut flut flut flut flut	ary weight loss. This affected 1 dents (#3). The lack of a lent, specific care planning and tation of intake resulted a lounds or 8% in three weeks. It: Idmitted on 4/28/06 with included CVA [stroke], leg, sacral stenosis, demential tic ulcer. Upon admission, the lound was documented as 132 was 5' 1-1/2 inches tall. Included 5/9/06, indicated the rely cognitively impaired and DL's. The resident required ince of one staff member to eat. In a least standard to the resident needed extensive faitus RAP Module dated 5/11/06 with the resident needed extensive faitus. The nursing RAP inted, "Res-[ident] at times is fing and will not feed herself, and cuing to eat and drink." Included intake of over 75% of ins and symptoms] of gnificant weight loss." The included intake of over 75% of ins and symptoms] of gnificant weight loss." The oaches included: (1) Regular inal enhanced meals], small the supplement 4 ounces am, pm (3) FEP [fluid enhancement referral, (5) allow ample time to lid, (6) encourage food and fluid	F	325	3. The resident's family has resident menu cycle from the department with the dietary supand has circled the food choice they felt their mother, per her would enjoy since the reside dementia and is unable to state in preferences. This is to assist in to increase the resident's food into increase the resident field as possible increase. Systemic Changes: 1. Refer to: F- 272, F-279. F-305. The interdisciplinary team member inserviced on weekly monitoring, assessment, documentation as well as the Matabase assessment, documentation and care planning by the Consultant. 2. The Minimum Data Set (MI Resident corresponding care planning of weekly be interdisciplinary team and the accuracy per the weekly be interdisciplinary team and the accuracy per the weekly Minimum Set (MDS) schedule. Monitor: 1. Dietary Supervisor and monitor the obtaining of weekly and the documentation of obtained into the clinical record corresponding weight summare assessments required for weekly review for accuracy and contribute includes reviewing and the residents' existing care applicable. 2. The Dietary supervisor and will monitor meal monitor completion and accuracy week includes meal percentage comeal replacement documentation of obtained replacement documentation.	dietary bervisor es that history nt has ber food helping take. tentially Ders will weight and dinimum assure entation orporate DS) and ans will y the DNS for um Data DNS to weights and any ries or y weight mpletion. updating plan as the DNS ors for ly. This insumed,	
	intake and identify	y and cut food for resident.			supplements as well as HS snac	ks.	9/2/2006

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MARQUIS CARE AT SHAW MT (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 325 Continued From page 72 P09 RESERVE ST BOISE, ID 83712 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 325	/2006
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 325 Continued From page 72 PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX TAG PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 325	
	(X5) COMPLETION DATE
The dietary assessment, dated 5/4/06, indicated the resident should have weekly weights. The weight summary documented the resident's weight on 4/28/06 as 132 pounds and on 5/18/06 as 120 pounds. This constituted a 12 pound loss in 3 weeks. The resident's "Meal Intake" records from May 1-18, 2006 revealed the following: The resident consumed an average of 35% of breakfast, 21% of lunch, and 21% of dinner. The documentation revealed the resident refused 8 meals in 18 days. On the days the resident refused a meal, or ate less than 50% of a meal, the house supplement was documentation to indicate whether or not she was offered an alternate choice. Snacks were documented as follows: AlM snacks accepted 3 times, refused 10 times and not documented 5 times, PM snacks were documented as offered and accepted on May 11 and 12th with no other documentation, HS (bedtime) snacks were documented as offered and accepted on May 10 and 15th with no other documentation to show that snacks were offered on other days. The documentation on the meal monitor was inconsistent. The records indicated a lack of offering the house supplement to the resident and lack of documentation of any alternate foods or snacks offered to the resident. This made it difficult to determine the resident's actual intake. The resident's Weight Flow Sheet documented the following:	

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Continued From pa	age 73	F 325	5		
Weight 134 pound breakfast, 35 % for Continue to monitor has lost 14 pounds averages 45% of be of dinner. Report independence in feed 2-3 finger foods and weights." Weekly weights we however, weights weights." Weekly weights we however, weights was during this period weight. The Dietary Assess the resident had so admission, the resident had so admission to the solution of the pounds of the present body weight (the repounds)."	s. Resident averages 18 % for r lunch and 10 % for pm meals. or on weekly weights, 5/18/06, since last week, meal intake breakfast 21% of lunch and 43 at that resident had decreased beding self. Will request to add and continue to monitor weekly ere to be done and recorded; were only documented on and on 5/18/06 (15 days later). Feriod of time the resident lost sment, dated 5/4/06, indicated one "negative behaviors" since ident was above IBW - [ideal JBW [usual body weight] 123 intake was poor, "Suspect ie. Will suggest regular, nem clarify Protein supplement to a TID [three times a day] onitor closely." The etary assessment notes ing: "Resident down 11 pounds ion and was likely related to mass given for 2 days on 5/11 oss occurred between 5/11 - t weight is closer to the usual esident's current weight is 119				
Review of the nurs	e s notes revealed the				
	SUMMARY ST. (EACH DEFICIENCY REGULATORY OR INCIDENCE R	ROVIDER OR SUPPLIER S CARE AT SHAW MT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 73 "4/28/06, Admission weight 132 pounds, 5/3/06, Weight 134 pounds. Resident averages 18 % for breakfast, 35 % for lunch and 10 % for pm meals. Continue to monitor on weekly weights, 5/18/06, has lost 14 pounds since last week, meal intake averages 45% of breakfast 21% of lunch and 43 % of dinner. Report that resident had decreased independence in feeding self. Will request to add 2-3 finger foods and continue to monitor weekly weights." Weekly weights were to be done and recorded; however, weights were only documented on admission (5/3/06) and on 5/18/06 (15 days later). It was during this period of time the resident lost weight. The Dietary Assessment, dated 5/4/06, indicated the resident had some "negative behaviors" since admission, the resident was above IBW - [ideal body weight] and UBW [usual body weight] 123 pounds, but meal intake was poor, "Suspect weight will decrease. Will suggest regular, nem small portions diet, clarify Protein supplement to House supplement TID [three times a day] between meals. Monitor closely." On 5/26/06, the Dietary assessment notes included the following: "Resident down 11 pounds (8%) since admission and was likely related to starting of Lasix 20 mgs given for 2 days on 5/11 and 5/12. Weight loss occurred between 5/11 - 5/18 so the present weight is closer to the usual body weight (the resident's current weight is 119	ROVIDER OR SUPPLIER S CARE AT SHAW MT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 73 F 325 "4/28/06, Admission weight 132 pounds, 5/3/06, Weight 134 pounds. Resident averages 18 % for breakfast, 35 % for lunch and 10 % for pm meals. Continue to monitor on weekly weights, 5/18/06, has lost 14 pounds since last week, meal intake averages 45% of breakfast 21% of lunch and 43 % of dinner. Report that resident had decreased independence in feeding self. Will request to add 2-3 finger foods and continue to monitor weekly weights." Weekly weights were to be done and recorded; however, weights were only documented on admission (5/3/06) and on 5/18/06 (15 days later). It was during this period of time the resident lost weight. The Dietary Assessment, dated 5/4/06, indicated the resident had some "negative behaviors" since admission, the resident was above IBW - [ideal body weight] and UBW [usual body weight] 123 pounds, but meal intake was poor, "Suspect weight will decrease. Will suggest regular, nem small portions diet, clarify Protein supplement to House supplement TID [three times a day] between meals. Monitor closely." 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ROVIDER OR SUPPLIER S CARE AT SHAW MT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MIST DE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 73 "4/28/06, Admission weight 132 pounds, 5/3/06, Weight 134 pounds. Resident averages 18 % for breakfast, 35 % for funch and 10 % for pm meals. Continue to monitor on weekly weights, 5/48/06, has lost 14 pounds since last week, meal intake averages 45% of breakfast, 35 % for funch and 43% of dinner. Report that resident had decreased independence in feeding self. Willi request to add 2-3 finger foods and continue to monitor weekly weights." Weekly weights were to be done and recorded; however, weights were only documented on admission (6/3/06) and on 5/18/06 (15 days later). It was during this period of time the resident lost weight. The Dietary Assessment, dated 6/4/06, indicated the resident had some "negative behaviors" since admission, the resident was above IBW - [ideal body weight] and UBW [jusual body weight] 123 pounds, but meal intake was poor, "Suspect weight will decrease. Will suggest regular, nem small portions diet, clarify Protein supplement to House supplement TID [three times a day] between meals. Monitor closely." On 5/26/06, the Dietary assessment notes included the following: "Resident down 11 pounds (8%) since admission and was likely related to starting of Lask 20 mgs given for 2 days on 5/11 and 5/12. Weight loss occurred between 5/11 - 5/18 so the present weight is closer to the usual body weight (the resident's current weight is 119 pounds)."

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(X4) ID PREFIX TAG	(EACH DEFICIENCY)	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 325	following document *5/5/06, "Feeds sel staff when resident *5/6/06, "To dining needs extensive as *5/7/06, "Refused and symptoms of a Risperdal and Depa *5/9/06" No s/s [si reaction to increase *5/10/06, "Refused have a 100% shake *5/11/06, "Appetite *5/12/06 - "Reside received order for four hours while aw 250 mgs q am, 500 *5/14/06, "Feeds s poor." *5/15/06, "Feeds s therapy." An Occupational th 6/20/06, after the w resident's independent to poor vision. On 7/24/06 at 12:50 observed in the din could barely hold how as very sleepy. Si slightly tipped the cobserved again in the dozing in the chair. of her meal. The Cleat much and starts	f some of the time, assisted by allows. Appetite poor." room for meals, feeds self but sist also." to get up for lunch, no signs dverse reaction to increase akote." gns and symptoms] adverse in Depakote and Zyprexa". I to get up for breakfast, did e." poor." Intreturned from Dr's office of Narco 5/325- 1-2 q [every] wake increase Depakote to	F 325			

NAME OF PROVIDER OR SUPPLIER MARQUIS CARE AT SHAW MT CAN D		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/ÇLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		CONSTRUCTION	(X3) DATE S COMPL	
MARQUIS CARE AT SHAW MT STREET ADDRESS, CITY, STATE, ZIP CODE 999 RESERVE ST BOISE, ID 83712			135090	B. WIN	G		08/0	2/2006
FREETX TAG (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 325 Continued From page 75 was observed sitting with her head on the dining table. The care plan did not include the resident's resistive behavior and poor vision, pain and medications i.e., Narco, Risperdal and Depakote, as factors placing her at risk for weight loss. After the weight loss the resident was placed in the restorative dining room on 5/19/06. The care plan was not individualized or revised as needed to reflect the various interventions tried by the staff to encourage the resident to eat or what action to take when the resident refused to eat. Alternate food choices the resident preferred were not included in the plan. The care plan was also not individualized to reflect the amount of assistance the resident required with eating. The initial care plan for nutritional risk had not been revised as of 7/28/06. Due to the lack of a complete assessment, specific care planning and complete accurate documentation of intake it could not be			Т .		909	RESERVE ST		
was observed sitting with her head on the dining table. The care plan did not include the resident's resistive behavior and poor vision, pain and medications i.e., Narco, Risperdal and Depakote, as factors placing her at risk for weight loss. After the weight loss the resident was placed in the restorative dining room on 5/19/06. The care plan was not individualized or revised as needed to reflect the various interventions tried by the staff to encourage the resident to eat or what action to take when the resident refused to eat. Alternate food choices the resident preferred were not included in the plan. The care plan was also not individualized to reflect the amount of assistance the resident required with eating. The initial care plan for nutritional risk had not been revised as of 7/28/06. Due to the lack of a complete assessment, specific care planning and complete accurate documentation of intake it could not be	PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL	PREFI.	×	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	
	F 325	was observed sitting table. The care plan did not resistive behavior and medications i.e., National as factors placing the weight loss the restorative dining room. The care plan was inneeded to reflect the staff to encoura action to take when Alternate food choice were not included in also not individualize assistance the resion initial care plan for revised as of 7/28/00. Due to the lack of a specific care planning documentation of interests.	ot include the resident's and poor vision, pain and arco, Risperdal and Depakote, er at risk for weight loss. After resident was placed in the porn on 5/19/06. Interpretation of the resident refused or revised as e various interventions tried by ge the resident to eat or what the resident refused to eat. The care plan was ed to reflect the amount of dent required with eating. The nutritional risk had not been 16. Complete assessment, and and complete accurate take it could not be	F 3	25			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE S COMPL	
		135090	B. WING _		08/	02/2006
	PROVIDER OR SUPPLIER		9	REET ADDRESS, CITY, STATE, ZIP (09 RESERVE ST BOISE, ID 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 328 SS=D	proper treatment is special services: Injections; Parenteral and en Colostomy, ureter Tracheostomy car Tracheal suctionir Respiratory care; Foot care; and Prostheses. This REQUIREMED by: Based on observate determined the fasample residents the toenails. Finding Resident #10 was diagnoses that incidementia. Finding The admission MI indicated the resident stated the facility of the LN with the stated the facility of the LN with the stated the facility of the control of the regarding a referrance of the resident of the	ensure that residents receive and care for the following steral fluids; ostomy, or ileostomy care; re; reg; ENT is not met as evidenced ation and staff interview it was cility did not ensure 1 of 11 (#10) received proper care of regs include: admitted 6/24/06 with cluded CVA [stroke] and sinclude: DS assessment, dated 7/3/06, lent's cognition was severely was dependent for all care. nails were observed on 7/28/06 were thick, long and rough. urveyor during this observation, did refer residents to a podiatrist ow if this resident had been are. No additional information	F 328	Resident #10 has had toel and filed by facility licens	sed nurse on e with the who is the lthcare (POA) with Podiatry mber refused ons and more ther is at end that Podiatry ive and cause a they do not id nurses will the resident's ment on the administration is has been urses will also omfort during nue if any esident wears ther feet and injury. as potentially inserviced on needs and the be done in a ut in place to care needs.	9/2/2006

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE S COMPL	
		135090	B. WIN	IG		08/0	2/2006
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F 328	Continued From page cause nail bed ulco	age 77 erations in the elderly.	F3	328			
	Except when waive this section, the far registered nurse for a day, 7 days a well-except when waive this section, the far registered nurse to nursing on a full time. The director of nurnurse only when the occupancy of 60 of this REQUIREME by: Based on review of staff interview, it was not ensure that a rehours each day for 7/3/06, 7/9/06, and not ensure the DO supervising and madepartment. This has residents in the factors of facility Schedule" and the	ed under paragraph (c) or (d) of cility must designate a serve as the director of me basis. sing may serve as a charge refacility has an average daily rewer residents. NT is not met as evidenced facility staffing schedules and as determined the facility did registered nurse (RN) worked 8 4 of 21 days reviewed (7/2/06, 7/16/06). Also, the facility did N devoted full time to anaging the nursing ad the potential to affect all rillity. The findings include: "Is "Three-week Nursing as-worked schedules from revealed no RN coverage on	F3	354	Corrective Action: 1. The facility staffing coordin continue to complete the licensed staffing schedule with review daily to assure RN compliance needs are met additional part-time RN has be to assure compliance. Identification: All residents are identified as pobeing affected. Systemic Changes: 1. Staffing system remains the with staffing coordinator schedulicensed staff but with the addaily DON oversight to assure staffing requirements are met. 2. Staffing coordinator to staffing schedule and schedulin at the 24 hour report process Monitor: Administrator to monitor we assure compliance and at Assurance Committee.	monthly full DON staffing . An en hired otentially ee same uling the dition of daily RN review g needs	9/2/2006

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	s	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE S COMPLI	
		135090	B. WII	NG		08/0	2/2006
NAME OF PROVIDER OR SUF				9	REET ADDRESS, CITY, STATE, ZIP CODE 09 RESERVE ST IOISE, ID 83712		
PREFIX (EACH DEFI	CIENCY I	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
was interview had complete three-week in there was no 7/9/06, and 7 thought that it census was 6 2. The DON am. She state services since ago. She alse including nurshelp of the Retrained staff to responsible for MDS. F 367 SS=D Therapeutic content of the Retrained staff to responsible for MDS. F 367 SS=D Therapeutic content of the Retrained staff to responsible for MDS. This REQUIF by: Based on training physical state of the Retrained staff to responsible for MDS.	t 8:30 a red. The d the sursing RN co /16/06. This was intended she are the second and the second are the secon	ge 78 am, the facility's Administrator e Administrator indicated he staffing numbers for the schedule and acknowledged verage for 7/2/06, 7/3/06, He also indicated that he conly a requirement if the dents or above. erviewed on 7/28/06 at 10:00 was responsible for social ocial worker left one month d she oriented all facility staff d provided inservice with the Care Managers. She had blete the MDS and was accuracy of the completed EUTIC DIETS ust be prescribed by the IT is not met as evidenced beervations and staff armined the facility did not be provided with diets as onlysician. This affected 3 during tray line (#1, 9, 20).	F36	354	alternative source to mixing powder into meals when menu have liquid source that is when mixed with protein powder source to be utilized) Monitor: Dietary supervisor to complete audit to assure compliance with powder supplemental additional additional supplemental additional source to mixing powder supplemental additional supplemental additional supplemental additional supplemental additional supplemental additional supplemental additional supplemental s	dietary irces for as been otentially included protein does not boalatable er. (Milk	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE S COMPL	
		135090	B. WIN	IG		08/0	2/2006
	PROVIDER OR SUPPLIER	r ,		90	EET ADDRESS, CITY, STATE, ZIP CODE 09 RESERVE ST OISE, ID 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 367	a. Resident #1's tra receive one scoop of portions of protein withat he was on a lar receive two scoops Resident #1's July 2 documented, "large protein power per troposterion b. Resident #9, tray any of the protein protein powder at e 2006 recapitulation protein per meal." c. Resident #20's, treceive any of the protein at each mear recapitulation order ounce protein w[ith] As each of the trays surveyor stopped the kitchen staff acknowledges and so the protein staff acknowledges are protein staff acknowledges.	y was observed to only of protein powder and regular when his diet card indicated age protein diet and was to protein powder at each meal. 2006 recapitulation orders portions [with] 2 scoops ay." was observed to not receive owder when her diet card was to receive one scoop of ach meal. Resident #9's July orders documented, "1 scoop ay was observed to not rotein powder when her diet she was to receive one extra al. Resident #20's July 2006 as documented, "Add extra al. Resident #20's July 2006 as docu	F	367			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TPLE CONSTRUCTION	ONSTRUCTION (X3) DATE S COMPLE	
		135090	B. WING		08/0	2/2006
	PROVIDER OR SUPPLIER	Т	,	REET ADDRESS, CITY, STATE, ZIP COD 909 RESERVE ST BOISE, ID 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(XS) COMPLETION DATE
F 371 SS=F	This REQUIREMENT by: Based on observating facility did not ensure maintained in the focurfaces clean and surfaces clean and surfaces smooth ar contaminated equipment food 4) non food or sanitized, 5) storage potential to affect 1 in the facility, including the facility, including the facility of the facility in the facility, including the facility of the facility in the facility including were observed on the inside of the were observed to hinside of the bowl. A manager acknowled indicated that they will be a surface of the food-contact surface food-contact surface food under	ARY CONDITIONS - FOOD ore, prepare, distribute, and anitary conditions. AT is not met as evidenced on and staff interview, the re sanitary conditions were ollowing areas: 1) food contact sanitized, 2) food contact and free of pits 3) possibly oment in direct contact with contact surfaces clean and the of bowls. This had the condition of 11 sampled (8-11). Findings include: 105 am, during an observation (8 out of 21 plastic coffee of to have a built up of residue cup and 6 out of 15 bowls ave dried food debris on the latt this time the dietary dige this observation and would get re-washed. Ition 601.11 of the 2005 indicates, "(A) Equipment es and utensils shall be clean	F 371	1. Residents #1-6 and #8-11 affected had re-wash of bowls during the survey. 2. Dishes that were pit replaced immediately. 3. The appropriate use of the when testing food sound completed by demonstratidietary staff with return dem to assure compliance 4. The fan in the kitchen was by maintenance Identification: All residents are identified as pleing affected. Systemic Changes: 1. All dietary staff was insee appropriate dish washing tech assure that no dried substresidue is present. 2. All dishes are to be more the dietary supervisor for replancessary if any pitting occurs. 3. Dietary supervisor inservice staff on appropriate the sanitizing procedures verbally demonstration. 4. Cleaning of the fan has be on routine maintenance schedule. 5. Dietary supervisor inservice staff on the requirement to mixing bowl. Monitor: 1. Dietary supervisor will thermometer sanitizing we compliance 2. Dietary supervisor will me	and cups ted were rmometer tes was on with onstration s cleaned cotentially rviced on iniques to ances or ditored by icement if ed dietary rmometer y and by en placed cleaning ed dietary cover the Monitor ekly for ionitor all	
	of food preparation,	:05 am, during an observation 4 out of 21 plastic coffee 5 plastic bowls were observed		dishes replacement needs wee 3. Dietary Supervisor will me weekly for cleanliness. 4. Dietary supervisor will me mixing bowls are covered weekly	onitor fan nitor that	9/2/2006

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE S COMPLI	
		135090	B. WING		08/0	2/2006
	ROVIDER OR SUPPLIER S CARE AT SHAW M	Т		REET ADDRESS, CITY, STATE, ZIP.C 909 RESERVE ST BOISE, ID 83712	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 371	to have scratches, food contact portion acknowledged this she had recently recups. *Chapter 4, subsect Federal Food Code Food-Contact Surfa Free of breaks, ope inclusions, pits, and 3. On 7/26/06 at 12 of tray-line, a kitches the temperatures of tray-line. The kitches the stem of the thermomember was obserint to the tetrazzini so of the thermometer food. *Chapter 3, subsect Federal Food Code contaminated by foothers though contadischarges, such a other means shall the dirty dishes and dietary manager activity and needed to that maintenance were contaminated by the dirty and needed to that maintenance were contaminated by the dirty dishes and dietary manager activity and needed to that maintenance were contaminated by the dirty and needed to that maintenance were contaminated by the dirty and needed to that maintenance were contaminated by the dirty and needed to that maintenance were contaminated by the dirty and needed to that maintenance were contaminated by the dirty and needed to that maintenance were contaminated by the dirty and needed to that maintenance were contaminated by the dirty and needed to that maintenance were contaminated by the dirty and needed to that maintenance were contaminated by the dirty and needed to the d	pits, and scoring on the inside in. The dietary manager observation and indicated that place some of the bowls and tion 202.11 of the 2005 indicates,"(A) Multiuse aces shall be: (1) Smooth; (2) in seams, cracks, chips, I similar imperfections" 1:20 pm, during an observation in staff was observed to take feach food item on the in staff was observed to diprementer into a sanitizing it sanitize the bottom of the meter. The kitchen staff ved to push the thermometer of that the bottom of the head was in direct contact with the tion 701.11 of the 2005 indicates,"(D) Food that is od employees, consumers, or act with their hands, bodily is nasal or oral discharges, or	F 37			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL. A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		135090	B. WING		08/02/2006
	ROVIDER OR SUPPLIER S CARE AT SHAW M	· .		REET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE ST BOISE, ID 83712	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLÉTION
F 371	Continued From pa	ge 82	F 371		
	Federal Food Code Nonfood-contact su kept free of an accuresidue, and other of 5. On 7/26/06 at 11 clean mixing bowl vupright and uncove dietary manager an	irfaces of equipment shall be umulation of dust, dirt, food debris." :05 am, in the kitchen, a large was observed to be stored red on the large mixer. The d the cook was not sure when			
	manager indicated the bowl should have inverted.	ast used. The dietary that she was not aware that ve been stored covered or			
	Federal Food Code Equipment and Ute specified under (A) stored: (1) In a self-	tion 903.11 of the 2005 indicates,"(B) Clean nsils shall be stored as of this section and shall be draining position that allows covered or inverted"			
	GARBAGE DISPOS	ARY CONDITIONS - SAL spose of garbage and refuse	F 372	Dietary manager exchanged garbage dumpster with the broke be used for cardboard and mark	en lid to ed it as
	properly.	, , , , , , , , , , , , , , , , , , ,		cardboard only to a covered in for kitchen refuse.	itact iid
	by: Based on observati	NT is not met as evidenced on and staff interview, the re sanitary conditions were		Identification: All residents are identified as point being affected.	tentially
	maintained with the	large garbage dumpsters. of 3 large dumpsters. Findings		Continued on p. 84	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE S COMPLE	
		135090	B. WIN	1G		08/0	2/2006
	ROVIDER OR SUPPLIER S CARE AT SHAW M			9	REET ADDRESS, CITY, STATE, ZIP CODE 09 RESERVE ST BOISE, ID 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 372	On 7/24/06 at 8:35 the dry storage area dumpster was obse the kitchen full of garbage. The dietar garbage was picked they were currently dumpster that had a large dumpster that a lid and that they s	am, during an observation on a of the kitchen, a large rved outside the back door of arbage without a lid over the y manager indicated that the I up twice a week and that on a waiting list for a lid. She also indicated the held the cardboard waste had hould just switch out the large ne one currently holding the	F3	372	Systemic Changes: All staff was inserviced by supervisor and maintenance replacement of refuse and cardot the appropriate garbage dumpsto keep the kitchen refuse coverequired. (Please note that the facility coto be on a long waiting list for garbage dumpster containers) Monitor: Dietary supervisor and maintenant monitor weekly that lids on godumpsters are closed.	garding pard in ers and ered as ered as ered as ered ered ered ered ered ered ered ere	9/2/2006
F 431 SS=D	Drugs and biological labeled in accordant professional principal appropriate access instructions, and the applicable. This REQUIREMENT by: Based on observation determined the facil locked medication redated after opening outdated. This had the residents who receive multidose vials. The	Is used in the facility must be ce with currently accepted es, and include the ory and cautionary expiration date when IT is not met as evidenced ons and staff interview, it was ity did not ensure that in 1 of 1 oom, multidose vials were or were discarded when he potential to affected any yed medication from the findings include:	F4	31	Identification: All residents are identified as pot being affected. Systemic Changes: All staff will be inserviced of appropriate dating of medication when opened as well as storage discard date protocols.	opened ed from r date 28 days s were armacy entially on the n vials	
		am, three 0.1 milliliter (ml) perculin was observed in the			Continued on p. 85		

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	
		135090	B. WI	1G	· · · · · · · · · · · · · · · · · · ·	08/0	2/2006
	ROVIDER OR SUPPLIER S CARE AT SHAW M	r		9(REET ADDRESS, CITY, STATE, ZIP CODE 09 RESERVE ST OISE, ID 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 431	room. All 3 had been Four 5 ml multidosed dated as expired or observed in the refrilocked medication round A LN was asked if shad been opened, so	elf, in the locked medication n opened and not dated. e vial of Influenza virus vaccine June 20, 2006 were igerator, on a shelf, in the oom. she knew when the Tuberculin she stated, "I don't know." She he Tuberculin should have	F	131	Monitoring: 1. Pharmacy Nursing Consult continue to monitor medication reappropriate drug storage, ladating and discarding per protocompliance. 2. DNS to audit the locked medication weekly for appropriate storage, labeling, dating and discof medications per protocol to compliance and at Quality Assistance Review.	oom for abeling, ocol for dication drug carding assure	9/2/2006
F 441 SS=E	infection control prosafe, sanitary, and of to prevent the devel disease and infection an infection control investigates, control the facility; decides isolation should be a resident; and mainta corrective actions results. This REQUIREMENT by: Based on interviews of facility and resided	tablish and maintain an gram designed to provide a comfortable environment and opment and transmission of on. The facility must establish program under which it is, and prevents infections in what procedures, such as applied to an individual ains a record of incidents and	F4	41	Corrective Action: 1. Resident's #4 and 5 were gipneumovaccine. 2. The facility infection control and logs continue to be utilized infection control review process additional form will be used to trends, clusters, and causative and preventative action plans in staff inservicing. Identification: All residents are identification potentially being affected.	reports d in the es. An identify factors ncluding	
	program that would to incidence of infec- were not investigate	ensure data collected, related tion, was analyzed. Infections d as to their potential cause not controlled and prevented			Continued on p. 86		

STATEMEN AND PLAN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION (X3) DATE S COMPL			
		135090	B, WING		08/0	2/2006	
	ROVIDER OR SUPPLIER S CARE AT SHAW M	Т	90	EET ADDRESS, CITY, STATE, ZIP CODE 19 RESERVE ST OISE, ID 83712			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 441	from spreading to a monitoring staff prato affect 100% of rewas determined the resident was offered vaccination. This was determined the resident was offered vaccination. This was determined the residents (#'s 4 & 5 anuary - July 2006 were as follows: January 2006 - UTURI [upper respirated skin -1, GI [gastroin February 2006, UT respiratory tract infoother -8 [4 admitted March 2006 UTI -5 other - 3. April 2006 UTI -5, UMay 2006 UTI -9, [a [admitted with - 4], June 2006, UTI -12 [discharged on 6/20 with 10 residents and July 2006. UTI - 10 as ongoing), LRI -1 There had been as	other residents of the facility by actices. This had the potential esidents of the facility. Also, it is facility did not ensure each did the pneumococcal as true for 2 of 11 sampled in the findings include: Sident Infection Logs from is were reviewed. The results I [urinary tract infections] - 4, fory tract infections] - 4, fory tract infections] 3, eye -1, fory tract infections] - 1, C-difficile. I - 5, URI -3, LRI [lower ections] - 4, eye -1, skin -3, d with]. JRI - 1, LRI -1, skin -2, other - 2. Idmitted with - 2], LRI - 7 Skin - 2 [MRSA]. C-difficile - 1. JRI - 3, Skin - 7, c-difficile - 1.	F 441	Systemic Changes: 1. DNS will be inserviced by Nurse Consultant on all Assurance forms and procedutilized in relationship to control as an adjunct to facility infection control program. 2. Admission Checklist will be by DNS to assure compliance pneumovaccine administrations. 3. The facility's Medical Direview all infections week adjunct to the facility's infect program for further processideration. Monitor: Administrator to monitor Assurance process for facility control program compliance with the Quality Assurance Control	I Quality ess to be infection y's current e reviewed e with the i. rector will ly as an ion control reventative Quality y infection weekly and	9/2/2006	

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION NG	(X3) DATE S COMPLI	
		135090	B. WII	۷G _	-	08/0	2/2006
	ROVIDER OR SUPPLIER S CARE AT SHAW M	Г		!	REET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE ST BOISE, ID 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPOPULATION OF TH	OULD BE	(X5) COMPLETION DATE
F 441		ge 86 ion - Monthly reports were y thought May 2006. June	F	141			
	and July reports for The two infection re information and the	2006 were not available. ports/logs contained different re was no documented ation was used in making					
	She provided the in reports and minutes working to reduce the	viewed on 7/28/06 at 2:30 pm. fection control inservices, s. She stated staff had been ne infections.					
	for April, May and Ji following:	une 2006 documented the					
	admitted with the int May 2006, the facility admitted with the int June 2006, 9 UTI's, and 7 facility acquire infections from the p log/report indicated infection control me reflected that leg ba residents, when up, catheters to reduce	y had 5 UTI's, 2 residents fection and 3 facility acquired. by had 5 UTI's, 2 residents fection and 2 facility acquired. 2 admitted with the infection ed, a 10 % increase in prior month. The monthly there were twelve UTI's. The eting minutes minutes gs were to be placed on all that have indwelling the amount of "cross e was scientific rational for to infection control.					
	provide enough info possible clusters of	used to collect data did not rmation to identify trends or infections. here was no tly monitor staff practices and					

PRINTED: 08/16/2006 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLET				
	135090	B. WING		08/0	2/2006
NAME OF PROVIDER OR SUPPLIER MARQUIS CARE AT SHAW M	л т	909	ET ADDRESS, CITY, STATE, ZIP CO PRESERVE ST DISE, ID 83712	DDE	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F315 and F444 for infection control. There were two incontrol conducted related to infection 2/27/06 with 12 sta 7/21/06 with 5 staf A published article "Epidemiology and term care facilities residents of nursin have special risk f disease, medicatic impairments. The types of endemic i these facilities: uri respiratory tract in pneumonia, and vinfections." The aran educational proand the use of a p decreased the infethat traditional appinfections still applications. The decreased the infethat traditional appinfections still applications. The decreased the infethat traditional appinfections still applications. The decreased the infethat traditional appinfections applications still applications. The decreased the infethat traditional appinfections applications applications applications applications. The decreased the infethat traditional applications applications applications applications applications. The decreased the infethat traditional applications	to change practices. Refer to a specific examples related to a services related to infection since January 2006. Inservice a control was conducted on aff attending and an inservice of attending. In 2001 by Strausbaugh LJ, a prevention of infections in long a homes in the United States actors including chronic ons, malnutrition and functional article documented, "Three infections occur regularly in all mary tract infections, lower fections - principally arious skin and soft tissue ticle indicated that in one study oram stressing handwashing ortable virucidal foam ection rate 50 % and confirmed proaches to prevention of ites. Is admitted to the facility on agnoses of Multiple Sclerosis, athy, restless leg syndrome,	F 441			

Event ID: BYUI11

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE S COMPLE	
	,	135090	B. WII	1G		08/0	2/2006
	ROVIDER OR SUPPLIER S CARE AT SHAW M	Г		90	EET ADDRESS, CITY, STATE, ZIP CODE 09 RESERVE ST OISE, ID 83712		
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F 441	administrator were documentation that offered the pneumo indicated she would On 7/26/06 at 9:05 resident #4 and 5 his pneumococcal vaccindicated that these this week. The DON telephone order for documenting conservated 7/25/06 documentated 7/26/06, documentated 7/26/06. Resident #5's physicated 7/25/06 documentated 7/26/06. Resident #5's physicated 7/25/06 documentated 7/26/06, documentated	o pm, the DON and facility asked to provide the residents #4 and 5 were recoccal vaccination. The DNS I look into the matter. am, the DON indicated ad not received the cination. The DON also resident would receive them I provided physician ms for both resident's nt to give the vaccination. cian telephone order form, mented, "May give A "Resident Vaccine Record" imented that resident #4 recoccal vaccination on cian telephone order form,	F	141			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBE,R:	(X2) MU A. BUIL	ULTIPLE CONSTRUCTION	(X3) DATE: COMPL	
		135090	B. WIN	G	08/	02/2006
	PROVIDER OR SUPPLIER S CARE AT SHAW M	Γ		STREET ADDRESS, CITY, STATE, ZIP C 909 RESERVE ST BOISE, ID 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	INFECTION The facility must recafter each direct reshandwashing is indiprofessional practic This REQUIREMENT by: Based on observation facility did not ensur handwashing and goirect resident care. residents (#1, 8 and (#21 and 28). Finding the CDC Guideline Hospital Environme documented the foll "a. Handwashing is procedure for preveb. The indications for depend on the type, sequence of activity chandwashing is in are used after situate contamination of the especially those involved in the contamination of the especial the contamination of the espe	on it was determined the se staff practiced appropriate love use before and after. This affected 3 of 11 sample 10) and 2 random residents ags include: Is for Handwashing and intal Control 1985, owing: the single most important inting nosocomial infections. In handwashing probably intensity, duration, and indicated, even when gloves ions during which microbial in hands is likely to occur, olving contact withbody hing inanimate sources that	F 4	All staff have been inser- regulation regarding hand all care and services. L have been inserviced on h and wound care infec- protocols for residents rec- care changes, wound medication administration differences between sterile techniques (Sterile dressing physician directed). This practice effecting resider and 28. Resident #2: discharged. Identification: All residents are potentially Systemic changes: 1. RCMs will monitor lice staff on medication pass, li	washing with icensed staff and washing tion control eiving wound cleansing, and the and aseptic gchanges are corrects the ase and seen affected affected affected affected affected affected affected affected affected cection control ing on new at licensed nurse weekly to ection control ing on new at licensed ing assistant appropriate the facility ses and to esident Care censed nurse training is infection ained. by or orientation are all areas of covered with inistrator will	9/2/2006

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ′	IULTIPL LDING	PLE CONSTRUCTION (X3) DATE : COMPL			
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.,	ROVIDER OR SUPPLIER S CARE AT SHAW N	17		909	ET ADDRESS, CITY, STATE, ZIP RESERVE ST ISE, ID 83712	·····		
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F 444	cirrhosis, diabetes Staphylococcus Archronic anemia, arresident was curre infection to a stage ischial tuberosity a ulcer on the right is The resident was a change on 7/25/06 the old dressing from the care for the first old dressing on the ischial tuberosity. It change her gloves hands in between a contaminated dress to change her gloves hands in between a contaminated dress to change her gloves hands in between a contaminated dress to change her gloves hands before clear cleansing the wour pocket with her con a pair of scissors to cutting the new dresserved to put the into her pocket with applying the clean to reach into her pocket with her contaminated the pocket with applying the clean to reach into her pocket with her pocket. Through the contaminate pocket. Through the contaminate pocket. Through the clean the pocket. Through the pocket the contaminate the contaminate the pocket. Through the pocket the contaminate the pocket. Through the pocket the contaminate the pocket.	mellitus 2, Methicillin Resistant ureus [MRSA], depression, and chronic leukopenia. The only being treated for a MRSA of IV pressure ulcer on the left and had a stage II pressure schial tuberosity. Observed during a dressing at 11:10 am. The LN removed form the wound on the resident's sity first. After removing the sing, the LN was not observed es before cleansing the wound an dressing. After completing of wound, the LN removed the resident's wound on the left. The LN was not observed to or to wash or sanitize her wounds. After removing the sing, the LN was not observed es or to wash or sanitize her not, the LN reached into her not an interest and got out or cut the new dressing. After essing to size, the LN was est contaminated gloves and got out or cut the new dressing. After dressing, the LN was observed observed hand. After dressing, the LN was observed observed and pull out a Sharpie are contaminated gloves. After dressing, the LN was observed on inated Sharpie pen back into thout this procedure, the LN to remove her contaminated or	F	144				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		135090	B. WIN	1G		08/0	2/2006
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F 444	After completing the the LN proceeded to repositioning the resolved movement are care. The LN got he pair of gloves from not observed to was before handling the removing her contare. A LN demonstrated practices during an dressing changes of MRSA. The LN's pocreated the potential increased the risk of other residents in the contare that the diameter of the contare that the potential increased the risk of other residents in the contare that the potential increased the risk of other residents in the contare that the diameter of the contare that the reside cognitively and required the person for all All "Skin Condition Profindicated the reside areas on the right be contared to the placed the dressing wiping the table or the placed the dressing wiping the table or the contare that the placed the dressing wiping the table or the contared that the placed the dressing wiping the table or the contared that the placed the dressing wiping the table or the care that the placed the dressing wiping the table or the care that the placed the dressing wiping the table or the placed that the placed the dressing wiping the table or the placed that the placed the plac	e wound dressing changes, o assist the CNA in sident. The resident had a nd required clean up and periorself and the CNA a clean a box on the wall. The LN was shor sanitize her hands clean gloves or after minated gloves. poor infection control observation of wound not a resident being treated for por infection control practices all for cross-contamination and final passing on infections to be facility. It is admitted to the facility on gnoses of CVA [stroke] and assessment, dated 7/5/06, and was severely impaired fined total assistance of one/or DL's including hygiene. It is wound dressing changes, a selection and period total assistance of one/or DL's including hygiene.	F 4	1444			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUILI	ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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F 444	from the resident's dressing, picked up the table to read the and applied a clean contaminated glove. Failure to follow as care placed the resincreased the risk oby staff moving from contaminated table. 3. Resident #8 was facility on 1/26/1998 with diagnoses inclustract infection), statiand cellulitis of the The most recent question from the contaminated cognition, care and had a sup An Interdisciplinary documented, " the small stage II ulcers on 7/28/06 at 11:00 LN change the dressore. The LN obtain a cart, placed the clobedside table without providing a barrier than the contaminated gloved, removed the wound and placed to the contaminated table without and placed the contaminated table.	buttocks, removed the soiled a container of Laniseptic from a label, cleansed the wound dressing without changing the es. eptic technique with wound ident at risk for infection. This of infection for other residents in room to room and handling is and supplies. originally admitted to the 5, and readmitted on 3/25/04, uding paraplegia, rogenic bladder, UTI (urinary us post venous thrombosis	F 44	44		

NAME OF PROVIDER OR SUPPLIER MARQUIS CARE AT SHAW MT SUMMARY STATEMENT OF DEFICIENCIES BOSE, ID 33712 FREET ADDRESS, CITY, STATE, ZIP CODE 900 RESERVE ST BOISE, ID 33712 PREFIX TAG FROVIDERS PLAN OF CORRECTION REGULATORY OR LISC IDENTIFYING INFORMATION) FREETY TAG Continued From page 93 contaminated glove adjusted the lighting with the light switch and replaced the clean dressing. The facility's wound care policy was reviewed. The following areas in the facilitys policy/procedure regarding dressing changes were not followed. a) Use disposable cloth [paper towel is adequate] to establish a clean field. b) Place all the terms to be used during the procedure on the clean field. c) Place disposable cloth under the wound to serve as a protection for the bed linen and other body sites. d) Put on exam glove and remove dressing, e) Putil the glove voer the dressing and discard in appropriate receptacle. Wash hands. f) Put on disposable gloves. g) Place one gauze over the broken skin, that is usually covered by the dressing, wash tissue around the wound. h) Remove dry gauze and apply treatment. Failure to follow aseptic technique during dressing changes placed residents at risk for infection. 4. An LN was observed on 7/25/06 at 12:38 pm during a medication pass. The LN was not observed to wash or santitze her hands before or after administering the eye drops. The LN was not observed to wash or santitze her hands immediately after leaving the residents room. 5. During a medication pass observation on	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) N A. BU		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
MARQUIS CARE AT SHAW MT Marguan Summary Statement of Deficiencies Summary Statement of Deficiencies PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX TAG PRE			135090	B. WI	₩	·	08/0	2/2006
FREETX TAG RECOULTORY OR LSC IDENTIFYING INFORMATION) F 444 Continued From page 93 contaminated glove adjusted the lighting with the light switch and replaced the clean dressing. The facility's wound care policy was reviewed. The following areas in the facilitys policy/procedure regarding dressing changes were not followed. a) Use disposable cloth (paper towel is adequate) to establish a clean field. b) Place all the Items to be used during the procedure on the clean field. c) Place disposable cloth under the wound to serve as a protection for the bed linen and other body sites. d) Put on exam glove and remove dressing. Plut on disposable gloves. g) Place one gauze over the broken skin, that is usually covered by the dressing, wash tissue around the wound. h) Remove dry gauze and apply treatment. Failure to follow aseptic technique during dressing changes placed residents at risk for infection. 4. An LN was observed on 7/25/06 at 12:38 pm during a medication pass. The LN was observed administering one eye drop. Into LN was not observed to wash or sanitize her hands immediately after leaving the resident's room.			ſ		9	09 RESERVE ST		
contaminated glove adjusted the lighting with the light switch and replaced the clean dressing. The facility's wound care policy was reviewed. The following areas in the facilitys policy/procedure regarding dressing changes were not followed. a) Use disposable cloth [paper towel is adequate] to establish a clean field. b) Place all the items to be used during the procedure on the clean field. c) Place disposable cloth under the wound to serve as a protection for the bed linen and other body sites. d) Put on exam glove and remove dressing. e) Puil the glove over the dressing and discard in appropriate receptacle. Wash hands. f) Put on disposable gloves. g) Place one gauze over the broken skin, that is usually covered by the dressing, wash tissue around the wound. h) Remove dry gauze and apply treatment. Failure to follow aseptic technique during dressing changes placed residents at risk for infection. 4. An LN was observed on 7/25/06 at 12:38 pm during a medication pass. The LN was observed administering one eye drop into both of random resident #28's eyes. The LN was not observed to wash or sanitize her hands before or after administering the eye drops. The LN was not observed to wash or sanitize her hands immediately after leaving the resident's room.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL	ULD BE	COMPLETION
	F 444	contaminated glove light switch and rep The facility's wound The following areas policy/procedure requere not followed. a) Use disposable of to establish a clean b) Place all the item procedure on the cleo) Place disposable serve as a protection body sites. d) Put on exam glove e) Pull the glove over appropriate receptant f) Put on disposable g) Place one gauze usually covered by the around the wound. h) Remove dry gauze usually covered by the around the wound. h) Remove dry gauze usually covered by the around the wound. h) Remove dry gauze usually covered by the around the wound. h) Remove dry gauze usually covered by the around the wound. h) Remove dry gauze dressing changes prinfection. 4. An LN was obsert during a medication administering one eresident #28's eyes wash or sanitize her administering the eyobserved to wash or immediately after legisters.	adjusted the lighting with the laced the clean dressing. I care policy was reviewed. In the facilitys garding dressing changes Cloth [paper towel is adequate] field. It is to be used during the lean field. I cloth under the wound to light of the bed linen and other light of the dressing and discard in cle. Wash hands. It is gloves. I over the broken skin, that is the dressing, wash tissue light of the dressing and discard in cle. Wash hands. I cloth under the wound to light of the dressing and discard in cle. Wash hands. I cle the dressing and discard in cle wash hands. I cle the dressing and discard in cle wash hands. I cle the dressing and discard in cle wash hands. I cle the dressing and discard in cle wash hands. I cle the dressing and discard in cle wash hands. I cle the dressing and discard in cle wash hands. I cle the dressing and discard in cle wash hands. I cloth under the wound to light of the dressing and discard in cle wash hands. I cloth under the wound to light of the dressing and discard in cle wash hands. I cloth [paper towel is adequate] I cloth [paper towel	F	144			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUIL	DING	(X3) DATE SURVEY COMPLETED		
		135090	B. WIN	G	08/	02/2006	
	PROVIDER OR SUPPLIER S CARE AT SHAW M	T ·	STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE ST BOISE, ID 83712				
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F 444	7/25/06 at 6:45 am, a resident's medica The LN was prepar resident #21. She s B-1 tablet cut in hal the medication with placing it in the pill sobserved to wash o preparing this resid An LN touched a reungloved hand pote to infection.	a LN was observed to handle tion with her ungloved hand. ing medications for random tated the resident liked the f and was observed picking up her ungloved hand and splitter. The LN was not r sanitize her hands before	F 4	44			
F 463 SS=D	resident calls through from resident rooms facilities. This REQUIREMENT by: Based on observation determined the facility portions of the call shower rooms on the potential to affect all shower room. Finding	must be equipped to receive the a communication system is; and toilet and bathing IT is not met as evidenced on and staff interview, it was ity did not ensure that all system were in working order. It is uminate outside of 1 of 2 e 200 hall. This had the residents who used this	F 46	The call light on the outside of hall shower room was repair the survey. Identification: All residents are identified as being affected. Systemic Changes: Maintenance supervisor to environmental rounds weekly areas that are in need of romplete the repair Monitor: Maintenance supervisor Administrator to audit envirounds weekly for compliance assure all needed repair completed. Audits will be resident to a supervisor and the s	potentially complete to identify repair and and ironmental ce and to irs were	9/2/2006	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		135090	B. WIN	IG		08/0	2/2006
	ROVIDER OR SUPPLIER	Т		90	EET ADDRESS, CITY, STATE, ZIP CODE 09 RESERVE ST OISE, ID 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 463	3:33 pm, the call lig from the nurses' statested. The light ou was found to be no man stepped out in situation and said, 'itthat's why it's no would replace the benvironmental inspective.	tht in the 2nd shower room ation in the 200 hall was tside the shower room door tworking. The maintenance to the hallway to assess the "Well, there's no bulb in tworking" He indicated he bulb immediately following the action. If the call light in the shower g of 7/26/06 and the call light	F4	163			
F 490 SS=H	enables it to use its efficiently to attain of practicable physical well-being of each run. This REQUIREMENT by: Based on observationand record review, was not administered.	dministered in a manner that resources effectively and or maintain the highest I, mental, and psychosocial esident. It is not met as evidenced on, staff and resident interview it was determined the facility ed in a manner that enabled it effectively and efficiently	F 4	90	Corrective Action: 1. Regarding #1, the facility proplan of correction during the sur 7/26/06 that was accepted at the with further request for addition of correction that was provided to Health and Welfare on 8/15/06 attached copy of addendum to the formal of correction. 2. Regarding # 2, See plan of corfor F-315 that was accepted on 7 by Idaho Health and Welfare. attached copy of plan of correction.	vey on le time al plan o Idaho . See ne plan rection //28/06 See	
	procedures specific and failed to demon emergency power of practice had the po-	to develop policy and to emergency power outage estrate knowledge on tutage procedures. This failed tential for harm constituting to residents' health and			Continued on p. 97		

	OF DEFICIENCIES OF CORRECTION	(X1) .PROVIDER/ŞUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		135090	B. WII	1G _		08/0	2/2006
	ROVIDER OR SUPPLIER S CARE AT SHAW M			9	REET ADDRESS, CITY, STATE, ZIP CODE 09 RESERVE ST BOISE, ID 83712		
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F 490	residents at risk for develop and implementerventions in a tirtract infections and practice resulted in health and safety. Tresidents (#'s 1, 2, 5) hospitalized in Decepyelonephritis that rin February 2006 with Resident #1 was hear a urinary tract infection assess, care plan of establish resident #0 of a foley catheter. being total incontine pubic catheter in plate as the social worker in place. The facility did not a for UTI and had no measures in place. Treated for a urinary survey. 3) At the time of the as the social service a social worker. The for staff development oversight of MDS at of DON supervision coverage for 4 of 20 three-week staffing.	to identify risks and assess urinary tract infection and to nent care plans and mely manner related to urinary catheter care. This failed serious harm to residents' This affected 4 of 11 sample 3 and 8). Resident #2 was ember of 2005 with required stent placement and ith a urinary tract infection. Sepitalized in May of 2006 with the did not a urinary tract infection. The facility did not a rimplement a procudure to 3's continence after removal. This resulted in the resident ent. Resident #8 had a supra face and was at risk for UTIs. The facility are assess resident #8 at high risk documented preventative. Resident #8 was being a tract infection during the survey, the DON was acting the survey, the pool was acting the survey, the pool was acting the procure of the lack of the facility did not ensure RN and as a procure RN	F	190	DNS responsibility load and in nursing system oversight the formusing system oversight the formusing system oversight the formusing system oversight the formusing have their duties redistribut include Minimum Data Set (completion. b. The facility is actively in the hiring process of a Social Social Social Social Service Consultant verside site visits weekly to the social Service Director can hired and trained. c. All of the department many currently participate in the staff development of each their assigned department and assist in the orientation new facility employees and continue to do so. d. See F-354 regarding staff coordinator's and DNS' responsibilities in relation to compliance with 8 hour coverage. 4. See F-441 and F-444 for Plan Correction related to review improvements in facility infection process. 5. F-225 for plan of correct relationship to inservicing start correct and complete accides.	ncrease ollowing so will led to MDS) electrice reporate will on New be agers electron of all divill so will so will so will so will so will so many and control stion in traff on and acluding use and	
	to incidence of filler	Alon, was analyzed. Imedions			Continued on p. 98		ľ

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S COMPL	
		135090	B. WING		08/0	02/2006
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F 490	were not investigate and infections were from spreading to a monitoring staff praction. 5) The facility did not unknown origin wer rule out the possibil Findings include: 1. The facility failed procedures specific and failed to demore emergency power of practice had the posimmediate jeopardy safety. Please refer to F512 this immediate jeopardy safety. Please refer to F512 this immediate jeopardy safety. 2. Urinary Tract Infects Assessments a. Resident #2 was facility on 7/31/03 a diagnoses including retention, and histor (UTI) and pyeloneple 6/6/06, the resident placed. Prior to that catheter in place du	ed as to their potential cause not controlled and prevented ther residents of the facility by ctices. In the ensure that injuries of the entire that injuries of the enti	F 490	Systemic Changes: 1. The DNS with the ass Corporate Nurse Consulta the Resident Care Manager descriptions and inservice of the RCM roles to red coverage currently being the DNS. 2. The Corporate Nurse Cassure 20 hours per wee and education to assure that are met and facility is in complete to F- 225, F-2: 354, F-441, and F-444 systemic corrections in rethis area. Monitor: Monitor: Monitoring of all areas to DNS, Administrator an Nurse Consultant week Quality Assurance Commit compliance.	nt will review r's job in the areas uce the RCM completed by Consultant will ek of support training needs ompliance. 50, F-315, F- for further elationship to take place by d Corporate ly and with	9/2/2006

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 490	12/20/05 for pyeloniplacement. The reson 2/22/06 for a urin. At the time of the sumeasures in place transcriptions. b. Resident # 1 was facility on 10/19/05 on 5/23/06 with diag decubitus ulcer, ost cirrhosis, diabetes in Staphylococcus Aurichronic anemia, and resident had a supreneurogenic bladder. Prior to the resident been in a local hospurosepsis. The resident place transcription in place transcriptions. Please refer to F318 information regard in 3. The facility did not nurse (RN) worked days reviewed (7/2/17/16/06). Also, the facility did not nurse (RN) worked days reviewed (7/2/17/16/06). Also, the facility did not nurse (RN) worked days reviewed (7/2/17/16/06). Also, the facility did not nurse (RN) worked days reviewed (7/2/17/16/06). Also, the facility did not nurse (RN) worked days reviewed (7/2/17/16/06). Also, the facility did not nurse (RN) worked days reviewed (7/2/17/16/06).	ospitalized from 12/14 to ephritis that required stent ident was again hospitalized hary tract infection. urvey, the facility had no to prevent urinary tract s originally admitted to the and most recently readmitted gnoses including Quadriplegia, reomyelitis, pancytopenia, mellitus 2, Methicillin Resistant reus [MRSA], depression, d chronic leukopenia. The apubic catheter due to a chronic leukopenia treated for dent was admitted to the for a urinary tract infection. urvey, the facility had no to prevent urinary tract for further details including residents #3 and #8. ot ensure that a registered 8 hours each day for 4 of 21 of 7/3/06, 7/9/06, and facility did not ensure the DON supervising and managing the	F 4	190			
				- 1			l i

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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F 490	At the time of the sign the social services a social worker. The staff development is oversight of MDS at the social services. Please refer to F25 social services. Please refer to F35 RN coverage. 4. The facility failed program that would to incidence of infections were not investigate and infections were from spreading to omonitoring staff pratically program that would to incidence of infections were from spreading to omonitoring staff pratically program that would to incidence of infections were from spreading to omonitoring staff pratically program that would to incidence of infections were from spreading to omonitoring staff pratically program that would to incidence of infections were from spreading to omonitoring staff pratically program that would to incidence of infections were from spreading to omonitoring staff pratically program that would to incidence of infections were from spreading to omonitoring staff pratically program that would to incidence of infections were from spreading to omonitoring staff pratically program that would to incidence of infections were from spreading to omonitoring staff pratically program that would to incidence of infections were from spreading to omonitoring staff pratically program that would to incidence of infections were from spreading to omonitoring staff pratically program that would to incidence of infections were from spreading to omonitoring staff pratically program that would to incidence of infections were from spreading to omonitoring staff pratically program that would to incidence of infections were from spreading to omonitoring staff pratically program that would to incidence of infections were from spreading to omonitoring staff pratically program that would to incidence of infections were from spreading to omonitoring staff pratically program that we have the program that we hav	urvey, the DON was acting as designee in the absence of a DON was also responsible for in the facility and for RN ssessments. Of for further details related to 4 for further details related to to provide an infection control ensure data collected, related ction, was analyzed. Infections ed as to their potential cause not controlled and prevented ther residents of the facility by ctices. I and F444 for further details. of ensure that injuries of e thoroughly investigated to	F	490			
		·					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE S COMPL		
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F 492 SS=B	The facility must op compliance with all local laws, regulatio accepted profession that apply to profess such a facility. This REQUIREMEN by: Based on observation facility did not ensur posted on 7/24 and potential to affect all facility. Findings inclied on 7/24/06 at 12:33 staffing numbers be from the nurses' stated the clean utility of the board was "To directly underneath "LPN", and "CNA." Tollowing any of the The board was again appeared as described on 7/24/06 at 3:36 plank]", "LPN 2" and documentation on the CNA in training. The shift was not identified on 7/25/06 at 9:00 a exact information as	erate and provide services in applicable Federal, State, and ans, and codes, and with hal standards and principles sionals providing services in a little and providing services in a little and listed the job titles "RN", There were no numbers job titles. In observed at 3:00 pm and little and listed the job title and listed and the job card was not dated and the listed and the job card was not dated and the job card was not dated and the job card the job card contained the job card was not dated and the job card was n	F 49	Corrective Action: The Staffing Coordinator we shifts have staff assigned, worked posted daily. Licer make any corrections to posted schedule each shift. Identification: All residents are identified being affected Systemic Changes: Staffing Coordinator and liestaff will be inservice completion of the daily postings and their responsomplete and/or make complicable to each shift post. Monitoring: Administrator will audit posting compliance	date and shift need staff will on the daily as applicable. as potentially censed nurse and on the assignment assignment or sibilities to prections as sing.	9/2/2006	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 492	on 7/25/06 at 10:3 The facility was in accurate informat 3:25 pm. On 7/26/06 at 6:1 board was unchar 7/24/06 at 3:36 pr On 7/26/06 at 8:0 and "CNA 5" with The board was no identified. On 7/26/06 at 4:0 "LPN 2" and CNA RN as in-training, the shift was not i Due to the lack of information on the difficult for resider ascertain exactly the floor each shift was in the shift was not in the shift was not in the difficult for resider ascertain exactly the floor each shift was interested as the shift was not in the floor each shift was not in t	formed about the lack of ion on the board on 7/25/06 at 1 am, the information on the nged from the observation on m. O am, the board read "LPN 2" no numbers posted for RNs. of dated and the shift was not 1 ap, the board read "RN 1", 5. The board documented one The board was not dated and	F 492			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 514 SS=E	resident in accordar standards and prace accurately documer systematically organ. The clinical record rinformation to identification to i	aintain clinical records on each nice with accepted professional tices that are complete; nted; readily accessible; and nized. must contain sufficient ify the resident; a record of the ents; the plan of care and he results of any ming conducted by the State; IT is not met as evidenced view and record review it was facility did not ensure clinical sampled residents (#'s 1, 2, 3, olete and accurately gs include: admitted to the facility on gnoses of dementia, prosis, psychosis, and chronic arm, resident #5 was observed lining room eating his resident was finished a NA f he was finished eating and respond back. The NA took The surveyor several minutes for the meal monitor sheets to ded. The July meal monitor and an R (refused) was	F 514	1. Resident #5, see F-309 correction regarding inserving documentation accuracy of monitors to the certified assistant staff. 2. Resident #4, see F-279 correction regarding inservicing interdisciplinary team mem accurate care plan completion dating and initialing changupdates to the resident's care plan completion in regards to inservice documentation of meal monitor consumption, fluid consump meal replacement. 4. Residents # 2, 3, and 6 card documentation corrected for missed activity of daily living documentation. See F-309 correction in regards to documentation. See F-309 correction in regards to documentation for accuracy. 5. All certified nursing assis will be inserviced on activities living (ADL) documentation refusal of showers, reporting showers to licensed nursing streschedule or offer alternations shower, for example a bed bacontraindicated. Identification: All residents are ident potentially being affected. Systemic Changes: 1. See F-309 for meal in reviews and audits by Supervisor and DNS weekly. 2. Activity of daily living flow so be audited weekly by the Admand Staffing Coordinator to the staffing Coordinator t	plan of meal plan of mentation and most have previous meal plan of mentation that staff including refusal of aff and to meal plan of me	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 514	these items to the resident. Whether the NA indicate and that he thought thought thought that the resident which was made awith the surveyor with a sheet and indicated been offered an alto surveyor recorded this meal.	esident. The NA indicated that rvey was next to the resident the NA did not offer this items en the NA was made aware of ed that he did not offer them that another NA had and ident had refused that was ed the refusal. At this time the are of this. The DNS provided copy of the meal monitor I that the resident should have ernate and a supplement. The chat the resident ate 30% of cumented that the resident sive and supplement but also not of meal eaten incorrectly.	F5	514	Monitor: 1. See F-309 for monitoring pro DNS and Dietary Supervisor re meal monitor completion. 2. Administrator and coordinator to audit activity of living (ADL) flow sheets were ensure compliance and notify Dinservice follow up as applicative review at Quality Assurance Cormeeting.	garding Staffing of daily ekly to DNS for ole and	9/2/2006
	2. Resident #4 was 7/29/04 with the dia dementia, neuropat chronic pain, and un Resident #4's most a date on it when the 3. Resident #1 was facility on 10/19/05 on 5/23/06 with diag	admitted to the facility on gnoses of Multiple Sclerosis, thy, restless leg syndrome, rinary retention. recent care plan, did not have be care plan was initiated. originally admitted to the and most recently readmitted gnoses including Quadriplegia,		ALLE PARTIES CONTRACTOR OF THE PARTIES CONTR			
,	cirrhosis, diabetes r Staphylococcus Au neurogenic bladder leukopenia.	reomyelitis, pancytopenia, mellitus 2, Methicillin Resistant reus [MRSA], depression, , chronic anemia, and chronic dated 6/06, was not complete.					

	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER MARQUIS CARE AT SHAW MT STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE ST BOISE, ID 83712		
(X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
The resident's meal and fluid consumption was not documented on 6/28 (breakfast), 6/19 (lunch) and 6/23 (dinner). The facility did not document if a replacement was offered when the resident ate 50% or less of his meal on the following dates: Lunch: June 3rd and 5th Dinner: June 15th and 24th. The meal monitor, dated 7/06, was not complete. The resident's meal and fluid consumption was not documented on 7/23 (breakfast) and 7/24 (lunch). The facility did not document if a replacement was offered when the resident ate 50% or less of his meal on July 7, 8, 9 and 15 (dinner). 4. Resident #6 was admitted to the facility on 7/31/00 with diagnoses including pancreatitis, congestive heart failure, wrist injuiry, hypertension, osteoporosis, coronary artery disease and non-union fractures of C1 and C2 (cervical spine vertebrae). The "CNA Flow Sheet" was reviewed for 7/06. According to the flow sheet, the resident was to receive a shower (wice a week on Tuesdays and Fridays. There was no documentation to indicate the resident was bathed or refused to bathe on 7/14/ and 7/18. The meal monitor for 6/06 was not complete. The resident's meal and fluid consumption was not documented on 6/28 (breakfast), 6/17 (dinner) and 6/18 and 6/23 (dinner). The facility did not document if a replacement was offered when the resident ate 50% or less of her meal on June 4, 7, 9, 10 and 27 (breakfast) and June 15, 19, 27 and 28 (dinner).		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		E CONSTRUCTION	(X3) DATE S COMPLI	
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F 514	resident's meal and documented on Jul document if a repla resident ate 50% or The snack monitor The facility did not caccepted or refused 5, 6, 7, 9, 10, 11, 12, 21, 22, and 23. 5. Similar findings for to meal monitoring	I fluid consumption was not y 14. The facility did not cement was offered when the less of her meal on June 17. for 7/06 was not complete. document if the resident d a bedtime snack on July 2, 3, 2, 13, 14, 15, 16, 18, 19, 20, or residents #2 and #3 related and CNA flow sheets.	F 5		Corrective Action:		
	PREPAREDNESS The facility must traprocedures when the periodically review that staff, and carry out those procedures. This REQUIREMENT by: Based on observation determined the facion procedures specificated and failed to demore emergency power of practice had the point mediate jeopardy safety. At the time of least 7 residents determined the facion procedures are practiced in the point mediate jeopardy safety. At the time of least 7 residents determined the facion procedures are practiced in the point facility. At the time of least 7 residents determined the facility of the facility	ster and employees in emergency ney begin to work in the facility; the procedures with existing unannounced staff drills using and staff interviews, it was lity failed to develop policy and to emergency power outage instrate knowledge on outage procedures. This failed tential for harm constituting to residents' health and of the survey, the facility had at expendent on oxygen (sample of the survey), the facility had at expendent or oxygen (sample of the survey), the facility had at expendent or oxygen (sample of the survey), the facility had at expendent or oxygen (sample of the survey), the facility had at expendent or oxygen (sample of the survey), the facility had at expendent or oxygen (sample of the survey), the facility had at expendent or oxygen (sample of the survey), the facility had at expendent or oxygen (sample of the survey), and at least 8 residents on	F 5	8	Plan of correction for F-5 submitted and accepted by Ida and Welfare on 7/24/06. Refurther additions to the correction was made by Idal and Safety and this was comp	ho Health quest for plan of no Health leted and ease see correction	9/15/2006

Marquis Care at Shaw Mountain Plan of Correction for F518 J Addendum August 25, 2006

As reviewed with the Department of Health and Welfare Long Term Care Supervisor, Loretta Todd on 8/21/2006, the interim generator will remain in effect until the permanent generator can be on site and installed. Based on estimates for generator delivery and construction schedules, we are fairly certain the September 15, 2006 completion date for this project is still viable. If a revision to this date is needed, Loretta Todd will be notified via phone and in writing as to the necessary revisions.

Marquis Care at Shaw Mountain Plan of Correction for F518 J Addendum August 14, 2006

RECEIVED AUG 15 2006

Corrective Action: Phase One:

DIV. OF MEDICAID

A temporary generator will be placed on site and hooked into the existing automatic transfer box and wiring. This generator will be supplied by EC Power Systems in Boise, ID. The installation will be completed by Mountain Power Electrical Co., a licensed electrical contractor in Boise, ID. The temporary unit is diesel-powered and will provide 12kw of power to the facility in the event of a power outage. This project will be completed on Wednesday, August 16, 2006.

Staff will continue to follow the current policy and procedure regarding a power outage. In addition to the current procedure, the facility has 8 "K" oxygen tanks on site that are available for emergency use by residents on oxygen, if the need arises. There are six regulators available for use with the "K" tanks. A battery-powered suction machine has been purchased and is available for use if needed also. Staff will be inserviced on the use of the "K" tanks and the suction machine. This inservice will be completed by August 16, 2006.

Phase Two:

A permanent generator will be installed on site. The new generator will be a diesel-powered 30kw capacity unit manufactured by Kohler. (See attached specification sheet) This unit will be supplied by EC Power Systems and be installed by Mountain Power Electrical Co. This generator will supply emergency power to all existing areas powered by the current generator during a power outage situation. This project will also include wiring and installation of three (3) additional emergency power outlets throughout the facility. Specifically, outlets would be added to 100 Hall, 200 Hall, and Friendship House (locked unit) respectively. **This project will be completed by September 15, 2006.**

All staff will be inserviced regarding policy and procedure changes related to the new generator and aforementioned emergency plugs outlets

Identification:

All residents are identified as potentially being affected by this deficient practice.

Systemic Changes:

Emergency Power Outage policy and procedure to be reviewed by Administrator and Maintenance to ensure compliance.

Monitor:

Administrator and/or Maintenance Supervisor to audit staff knowledge of emergency power outage policy and procedure on a monthly basis for three months and then quarterly thereafter. QA Committee to review quarterly to ensure compliance.

Completion Date: September 16, 2006

Marquis Care at Shaw Mountain Plan of Correction for F518 J July 26, 2006

Corrective Action:

All staff to be inserviced on emergency power outage policy and procedures in order to maintain life safety in the facility in the event of a power outage.

Completion Date: 8/4/2006

Person Responsible: Joe Rudd, Administrator

Identification:

All residents are identified as potentially being affected by this deficient practice.

/ Systemic Changes:

Emergency Power Outage policy and procedure to be reviewed by Administrator and Maintenance Supervisor to ensure compliance.

Monitor:

Administrator and/or Maintenance Supervisor to audit staff knowledge of this policy and procedure weekly for four weeks and the quarterly thereafter. QA Committee to review quarterly to ensure compliance.

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F 518	airbeds (sample resand random resider This failed practice the facility's administ and the facility was failure to develop are procedures on eme. The facility was instremoval of the risk to implement corrective jeopardy situations. On 7/26/06 at 8:08 all staff on the shift immediately and a veconducted with mare 100% of staff that we and the next day shift regarding the emergent.	sidents #'s 1, 2, 4, 7, 8, and 9 ints # 's 22 and 23) was brought to the attention of stration on 7/26/06 at 7:47 pm provided specific details of the individuals and immediate to individuals and immediately in measures to prevent repeat pm, the Administrator stated would be in-serviced walk through would be inagement staff. He stated was coming on for the night ift would be in-serviced	F 5	18			
		am, the Administrator ors with an acceptable plan of					
	The plan of correction	on was as follows:					
,	outage policy and pr	viced on emergency power rocedures in order to maintain lity in the event of a power		***************************************	-		
		Outage policy and procedure dministrator and Maintenance e compliance.		**			

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	(X3) DATE S COMPLE	
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F 518	audit staff knowledge weekly for four wee QA [Quality Assurant quarterly to ensure of Findings include: During the environm Maintenance Super the surveyor noted to generator in the even outlet was located in location or an facility. The maintenince in the red outlet of residents' rooms. The drills were held quare education was also orientation regarding and access instruction for 97 beds. At 5:08 pm on 7/26/regarding emergency outlet the maintenance mass the acknowledged are demergency outlet the maintenance mass the acknowledged are demergency outlet the surveyor noted to survey the surveyor noted to generate the su	r Maintenance Supervisor to ge of this policy and procedure ks and quarterly thereafter. Ince] Committee to review compliance." Inental inspection with the visor on 7/26/06 at 3:16 pm, the facility had one reduces power from the ent of a power outage. The reduce nan area where offices were enursing facility and the new and was not visible from the entered that care areas in the entered was not visible from the entered that care areas in the entered was not visible from the entered was not	F 518			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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F 518	location of the red procedures in the Initially she verball the system worked generator power at there was a power she would "find a routlet was in the conurses' station. A sinto the clean utility found. From 5:08 pm to 6 interviewed regard during a power our plug-in. Two employed Resident Care Mathe day shift knew and where the extrest of the staff, will did not. One LN stoutlets in the hallw where. She stated O2 [oxygen] concernation was reindicated he would the time, couldn't fwas not able produspecific to emerge in time before the As part of their pla	interviewed regarding the outlet and emergency event of a power outage. Ized no understanding of how did, indicating she assumed the utomatically "kicked on" when outage. She eventually stated red plug." She stated the red lean utility room near the surveyor accompanied the LN y room. No red outlet was a housekeeper and a nager, who normally worked the location of the red outlet ension cords were located. The nich included LNs and CNAs, ated she had seen "red ray" but could not specify, "you'd just plug things like	F 518			
	procedures.	, , ,				Artinologica

	T @F DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE S	
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	PROVIDER OR SUPPLIER			90	EET ADDRESS, CITY, STATE, ZIP CODE 09 RESERVE ST OISE, ID 83712		
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F-518	The Administrator v 6:56 pm regarding that staff's lack of knowled the emergency proceeding staff's lack of knowled the emergency procedure safety and said, enoughthere's not left the room at the check the new empsee how this issue we'we're going to insolve the facility's a informed of the immore 7/26/06 at 7:47 pm, staff on board now left on the shift immediately and a weconducted with mar 100% of staff that we and the next day should regarding the emergence of the time of surver (sample residents # #'s 19, 22, 24, 25, 20 oxygen, 8+ resident (sample residents # random residents # resident (#7) with the suctioning to maintate fed. Four of the resident on ouse of their experience of the staff of the staff of the resident of the resident of the resident of their experience o	vas interviewed on 7/26/06 at the emergency outlet and edge about its location and cedure. He stated this was a red in orientation along with "but apparently not the much else I can say" He conclusion of the interview to loyee orientation packet to was addressed. He said, ervice staff tomorrow" administrative staff was nediate jeopardy situation on the administrator stated, "All nave been in-serviced." om, the Administrator stated would be in-serviced walk through would be nagement staff. He stated was coming on for the night ift would be in-serviced	F	518			

	T GF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE S COMPLI	
		135090	B. WII	۷G		08/0	2/2006
	PROVIDER OR SUPPLIER S CARE AT SHAW M	Г		90	REET ADDRESS, CITY, STATE, ZIP CODE 09 RESERVE ST BOISE, ID 83712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 518	residents risked suf- deflate in the event area had undergone degree temperature threatening a power company was consi- to the staff's lack of during an emergency that the facility could procedures address	focation if the beds were to of a power failure. The local e multiple days of at least 100 es and because of forest fires a supply, the local power idering rolling blackouts. Due knowledge about procedures by power outage and the fact of not produce policy and sing this specific issue, it was idents were at risk for serious	F	518			

LENTERSI	FOR MEDICARE & MEDICAID SERVICES			- A FORN				
	OF ISOLATED DEFICIENCIES WHICH CAUSE ITH ONLY A POTENTIAL FOR MINIMAL HARM ID NFs	PROVIDER # 135090	MULTIPLE CONSTRUCTION A. BUILDING B. WING	DATE SURVEY COMPLETE: 8/2/2006				
	OVIDER OR SUPPLIER S CARE AT SHAW MT	1	STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE ST BOISE, ID					
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIE	NCIES						
F 278	483.20(g) - (j) RESIDENT ASSESSMI	ENT						
	The assessment must accurately reflect	the resident's status.						
	A registered nurse must conduct or cooprofessionals.	ordinate each assessme	ent with the appropriate participation of	health				
	A registered nurse must sign and certify	y that the assessment	s completed.					
Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.								
	statement in a resident assessment is su assessment; or an individual who willfu	an individual who willfully and knowingly certifies a material and false ent is subject to a civil money penalty of not more than \$1,000 for each o willfully and knowingly causes another individual to certify a material and essment is subject to a civil money penalty of not more than \$5,000 for each						
	Clinical disagreement does not constitu	ite a material and fals	e statement.					
	This REQUIREMENT is not met as ex Based on observation, staff interview as accuracy of MDS assessments. This affi inaccurately recorded side rails as restra Findings include:	nd record review, it w fected 2 of 11 sample	residents (#'s 1 & 3). Resident #1's MD	S				
1. Resident # 1 was originally admitted to the facility on 10/19/05 and most recently readmitted on 5/23/with diagnoses including Quadriplegia, decubitus ulcer, osteomyelitis, pancytopenia, cirrhosis, diabetes mellitus 2, Methicillin Resistant Staphylococcus Aureus [MRSA], depression, neurogenic bladder, chronanemia, and chronic leukopenia. The resident was on an airbed for pressure relief to maintain skin integr								
Section P4 "Devices And Restraints" of an MDS dated 3/24/06, was coded to indicate the resident had full side rails on all open sides of the bed and the side rails were used daily.								
The MDS, dated 3/17/06, contained the same information in Section P4 as documented above.								
	The resident's most current MDS, dated	d 6/5/06, did not code	the full side rails as restraints.					
	The side rails were used to maintain the bed. The side rails were not being utiliz			ng out of				
	•							

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

	OF ISOLATED DEFICIENCIES WHICH CAUSE ITH ONLY A POTENTIAL FOR MINIMAL HARM D NFs	PROVIDER # 135090		MULTIPLE CONSTRUCTION A. BUILDING B. WING	DATE SURVEY COMPLETE: 8/2/2006			
	OVIDER OR SUPPLIER CARE AT SHAW MT	STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE ST BOISE, ID						
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIE	NCIES						
F 278	cataracts, glaucoma and dementia. An admission MDS, dated 5/9/06, docu	06 with diagnoses which included CVA [stroke], hematoma of left leg, cumented the resident had no impairments in vision or visual						
	poor"	ated 5/11/06, documented the following: "Nutrition:Resident eyesight is ring a meal on 7/25/06 at 8:23 am. The CNA sat beside the resident and told her						
	The resident's MDS was incorrectly co- coding, a RAP did not trigger and the r A Resident Care Manager responsible resident's vision and the accuracy of the stated, "it's a mis-code"	ded in relation to vision esident's visual deficit v	vas no tervie	ot care planned. wed on 7/27/06 at 12:35 pm rega	rding the			
	The MDS is a comprehensive assessme individualized care plan and enables the depends on the facility's ability to accurate.	e facility to track change	es in		this tool			

Boreau of Facility Standards

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		135090		B. WING_		08	/02/2006
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
C 000	annual State license The surveyors cond Lory Dayley, RD, Te Lisa Kaiser, RN Betty Vivian, RN, M: Survey Definitions: MDS = Minimum Da RAI = Resident Ass RAP = Resident Ass DON = Director of N LN = Licensed Nurs RN = Registered Nur RN = Certified Nur ADL = Activities of E	Rules of the Idaho Ith and Welfare, Intermediate Care in IDAPA 16, encies were cited du ure survey of your fa- lucting the survey we eam Coordinator SN ata Set assessment essment Instrument sessment Protocol lursing lie urse rse Aide	cility.	C 000	The following POC is being required by federal regular submission of this POC is construed in any way as by the facility of the deficition finding of fact. RECEIVI AUG 25 20 DIV. OF MEDI	lation. The s not to be an admission ency nor the	
	b. The administrate responsible for estal assuring the implementation policies and proceduservice offered by the through arrangement service and of the opphysical plant. The procedures shall fur out any instructions imposed as a result	blishing and nentation of written ures for each re facility, or nots with an outside peration of its policies and ther clearly set or conditions		C 107	Please refer to F	190	
Bureau of Fac	cility Standards				TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Búreau of Facility Standards

STATEMENT	OF	DEFICIE	NCIES
AND PLAN OF	CO	ORRECTI	ON

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

135090

A. BUILDING B. WING ____

08/02/2006

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MARQUIS CARE AT SHAW MT		909 RESERVE ST BOISE, ID 83712			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
C 107	Continued From page 1	C 107			
	beliefs of the owner or administrator. The administrator shall see that these policies and procedures are adhered to and shall make them available to authorized representatives of the Department. If a service is provided through arrangements with an outside agency or consultant, a written contract or agreement shall be established outlining the expectations of both parties. This Rule is not met as evidenced by: Please refer to F490 as it relates to the Administrator's failure to ensure the facil administered in a manner that enabled it its resources effectively and efficiently to betterment of each resident.	to use			
C 125	02.100,03,c,ix	C 125	Please refer to F 241		
	ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Please refer to F241 as it relates to the failure to ensure a resident's dignity in reprivacy.				
C 175	02.100,12,f	C 175	Please refer to F 225		
	f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Please refer to F225 as it relates to the facility Standards	acility's			

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MARQUIS CARE AT SHAW MT		909 RESERVE ST BOISE, ID 83712			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 175	Continued From page 2	C 175			
	failure to thoroughly investigate injuries of unknown origin.				
C 239	02.106,04 EMERGENCY PLANS PROTECT & EVACUATION	TION C 239	Please refer to F 518	4	
	04. Emergency Plans for Protection and Evacuation of Patients/Residents. In cooperation with the local fire authority, the administrator shall develop a written plan for employee response for protection of patients/residents in case of an emergency. The plan shall include at least the following: This Rule is not met as evidenced by: Based on observation and staff interviews, it determined the facility failed to develop policiprocedures specific to emergency power out and failed to demonstrate knowledge on emergency power outage procedures. This for practice had the potential for harm constitutir immediate jeopardy to residents' health and safety. At the time of the survey, the facility heast 7 residents dependent on oxygen (sam. resident #7 & random residents #s 19, 22, 24, 25, 26 and 27), 1 resident who required suctioning and was tube fed (#7), and at least residents on airbeds (sample residents #s 1, 4, 7, 8, and 9 and random residents # 's 22 a 23).	y and age alled age and at ple 4, st 8, 2, and			
	This failed practice was brought to the attention of the facility's administration on 7/26/06 at 7: pm and the facility was provided specific detaof the failure to develop and implement policy procedures on emergency power outage.	47 ails			
	The facility was instructed to begin immediate removal of the risk to individuals and immediality Standards				

Bureau of Facility Standards STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 135090 08/02/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE ST MARQUIS CARE AT SHAW MT **BOISE, ID 83712** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) C 239 Continued From page 3 C 239 implement corrective measures to prevent repeat jeopardy situations. On 7/26/06 at 8:08 pm, the Administrator stated all staff on the shift would be in-serviced immediately and a walk through would be conducted with management staff. He stated 100% of staff that was coming on for the night and the next day shift would be in-serviced regarding the emergency power outage procedures. At that time, the immediate jeopardy was abated. On 7/27/06 at 7:37 am, the Administrator provided the surveyors with an acceptable plan of correction. The plan of correction was as follows: "All staff to be inserviced on emergency power outage policy and procedures in order to maintain life safety in the facility in the event of a power outage. Emergency Power Outage policy and procedure to be reviewed by Administrator and Maintenance Supervisor to ensure compliance. Administrator and/or Maintenance Supervisor to audit staff knowledge of this policy and procedure weekly for four weeks and quarterly thereafter. QA [Quality Assurance] Committee to review quarterly to ensure compliance." Findings include: During the environmental inspection with the Maintenance Supervisor on 7/26/06 at 3:16 pm. the surveyor noted the facility had one red

emergency outlet to access power from the

Bûreau of Facility Standards STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING B. WING 135090 08/02/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE ST **MARQUIS CARE AT SHAW MT BOISE, ID 83712** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) C 239 Continued From page 4 C 239 generator in the event of a power outage. The red outlet was located in an area where offices were located, between the nursing facility and the new Alzheimer's wing, and was not visible from the nurses' station or any resident care areas in the facility. The maintenance man stated there were 2 locations to access extension cords and during a power outage, staff were to string extension cords from the red outlet down the various halls to residents' rooms. The maintenance man stated drills were held quarterly for each shift and education was also provided at new employee orientation regarding the location of the red outlet and access instructions. The facility was licensed for 97 beds. At 5:08 pm on 7/26/06, the DON was interviewed regarding emergency procedures during a power outage and the location of the red outlet. She stated she did not know and that she would call the maintenance man if the situation ever arose. She acknowledged she had no idea where the red emergency outlet was. At 5:11 pm on 7/26/06, the charge LN on the evening shift was interviewed regarding the location of the red outlet and emergency procedures in the event of a power outage. Initially she verbalized no understanding of how the system worked, indicating she assumed the generator power automatically "kicked on" when there was a power outage. She eventually stated she would "find a red plug." She stated the red outlet was in the clean utility room near the nurses' station. A surveyor accompanied the LN into the clean utility room. No red outlet was found. From 5:08 pm to 6:54 pm, a total of 9 staff were interviewed regarding emergency procedures

Bureau of Facility Standards **STATEMENT OF DEFICIENCIES** (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 135090 08/02/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE ST MARQUIS CARE AT SHAW MT **BOISE, ID 83712** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID. (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) C 239 Continued From page 5 C 239 during a power outage and the location of the red plug-in. Two employees, a housekeeper and a Resident Care Manager, who normally worked the day shift knew the location of the red outlet and where the extension cords were located. The rest of the staff, which included LNs and CNAs. did not. One LN stated she had seen "...red outlets in the hallway..." but could not specify where. She stated, "...you'd just plug things like O2 [oxygen] concentrators in..." On 7/26/06 at 6:03 pm. the maintenance man was unable to produce policy and procedures relating to emergency power outage when this information was requested by the surveyors. He indicated he would keep looking for them but at the time, couldn't find any. The maintenance man was not able produce policy and procedures specific to emergency power outage at any point in time before the immediate jeopardy was called. As part of their plan of correction, the facility created a policy and step-by-step written procedures. The Administrator was interviewed on 7/26/06 at 6:56 pm regarding the emergency outlet and staff's lack of knowledge about its location and the emergency procedure. He stated this was a topic that was covered in orientation along with fire safety and said, "...but apparently not enough...there's not much else I can say..." He left the room at the conclusion of the interview to check the new employee orientation packet to see how this issue was addressed. He said. "We're going to in-service staff tomorrow..." When the facility's administrative staff was informed of the immediate jeopardy situation on 7/26/06 at 7:47 pm, the administrator stated, "All staff on board now have been in-serviced."

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MUL A. BUILD B. WING		(X3) DATE : COMPI	
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NAME OF I	PROVIDER OR SUPPLIER				, STATE, ZIP CODE		
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C 239	Continued From pa	ge 6		C 239			
	all staff on the shift immediately and a viconducted with man 100% of staff that will and the next day shift regarding the emery procedures. At the time of surve (sample residents # #'s 19, 22, 24, 25, 20 oxygen, 8+ resident (sample residents # random residents # resident (#7) with the suctioning to maintain fed. Four of the resident or no use of their ex #'s 1, 2, & 8 and rander residents risked suffer the experience of the staff's lack of during an emergency that the facility could procedures address	pm, the Administrato would be in-serviced walk through would be nagement staff. He sivas coming on for the ifft would be in-serviced gency power outage y, there were 7+ residency power outage y, there were 7+ residency power on air be if s 1, 2, 4, 7, 8, and 9 is 22 and 23) and on roat cancer who also ain an airway and was dents on airbeds had attremities (sample residom resident #23). If focation if the beds wo f a power failure. The multiple days of at less and because of fore supply, the local power outage and it is a power outage and it is specific issued dents were at risk for mediate jeopardy.	e tated e night ed dents esidents on ds and e sample required stube limited sidents hese rere to be local east 100 est fires est. Due ocedures the fact and e, it was				
C 293	02.107,04,b			C 293	Please refer to F 367	The state of the s	
	b. Therapeutic oplanned in accordant physician's order. To it is medically possible to the property of the pro	ce with the the extent that	T y propriet white the propriet was an analysis of the propriet which we have the propriet which we ha				

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NAME OF F	ROVIDER OR SUPPLIER	100000	STREET ADI	DESS CITY	, STATE, ZIP CODE	<u> U8/C</u>)2/2006
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C 293	planned from the re shall meet the patie daily need for nutrie This Rule is not me Please refer to F36	egular menu and ent's/resident's ents. et as evidenced by: 7 as it relates to the f		C 293		·	
C 325	diets as prescribed 02.107,08 FOOD S. 08. Food Sanitation	ANITATION on. The	ı with	C 325	Please refer to F 371		
		nd drink in a with Idaho th and Welfare pter 19, "Rules nitation Standards nents (UNICODE)."					
		and refuse shall be ole, nonabsorbent ot leak or absorb shall be provided unless stored ns or enclosures, rator.	acility's	C 336	Please refer to F 372		

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED
	135090	B. WING	08/02/2006

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MARQUIS CARE AT SHAW MT		909 RESERVE ST BOISE, ID 83712				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY TAG REGULATORY OR LSC IDENTIFYING INFORMATION		/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 342	Continued From page 8		C 342			
C 342	02.108,04,b,ii		C 342	Please refer to F 323		
	ii. All toxic chemicals shall be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Please refer to F323 as it relates to prop storage of toxic chemicals.	per				
C 361	02.108,07 HOUSEKEEPING SERVICES EQUIPMENT	S AND	C 361	Please refer to F 253		
	O7. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Please refer to F253 as it relates to the failure to ensure adequate housekeeping maintenance services to maintain the intent the facility.	acility's				
C 393	02.120,04,b	***************************************	C 393	Please refer to F 246 & F 463	ALL TO SERVICE STATES AND SERVIC	
	b. A staff calling system shall be installed at each patient/resident bed and in each patient/resident toilet, bath and shower room. The staff call in the toilet, bath or shower room shall be an emergency call. All calls shall register at the staff station and shall actuate a visible signal in the corridor at the patient's/resident's door. The activating mechanism within the patient's/resident's sleeping room					

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(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

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(X3) DATE SURVEY COMPLETED

135090

B. WING ___ STREET ADDRESS, CITY, STATE, ZIP CODE

MARQUIS CARE AT SHAW MT

NAME OF PROVIDER OR SUPPLIER

909 RESERVE ST

MARQUIS CARE AT SHAW MT		DISE, ID 83712	·		
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C 393	Continued From page 9	C 393			
	shall be so located as to be readily accessible to the patient/resident at all times. This Rule is not met as evidenced by: Please refer to F246 as it relates to accessit of call lights. Please refer to F463 as it relates to call light registering a visible signal in the corridor.				
C 669	02.150,03 PATIENT/RESIDENT PROTECTI	ION C 669	Please refer to F 444		
	03. Patient/Resident Protection. There is evidence of infection control, prevention and surveillance in the outcome of care for all patients/residents as demonstrated by: This Rule is not met as evidenced by: Please refer to F444 as it relates to the facilit failure to ensure staff demonstrated appropri handwashing and glove use during direct residence.	iate			
C 670	02.150,03,a	C 670	Please refer to F 441		
***************************************	a. Applied aseptic or isolation techniques by staff. This Rule is not met as evidenced by: Please refer to F441 as it relates to the facilit failure to ensure staff demonstrated appropri infection control measures during direct residuants.	ate			
C 696	02.152 SOCIAL SERVICES	C 696	Please refer to F 250		
	152. SOCIAL SERVICES. The facility shall provide for the identification of the social and emotional needs of the		·		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STATE, ZIP CODE	
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MARQUIS CARE AT SHAW MT		909 RESERVE ST BOISE, ID 83712				
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C 696	Continued From page 10 patients/residents either directly or through arrangements with an outside resource and shall provide means to meet the needs identified. The program shall be accomplished by: This Rule is not met as evidenced by: Please refer to F250 as it relates to the fac failure to ensure residents were provided medically-related social services.	C 696				
C 745	c. Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Please refer to F281 as it relates to the facifailure to ensure services provided met professional standards of quality.	C 745	Please refer to F 281			
	i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses; This Rule is not met as evidenced by: Please refer to F272 as it refers to the facili failure to ensure comprehensive assessme are completed for each resident.		Please refer to F 272			
	iii. Written to include care to be given, goals to be accomplished, actions necessary to attain the goals and which service is responsible for each element of care;	C 781	Please refer to F 279			

Bureau of Facility Standards

(X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING B. WING _ 08/02/2006 135090 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER

MARQUIS CARE AT SHAW MT		909 RESERVE ST BOISE, ID 83712			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 781	Continued From page 11		C 781		
	This Rule is not met as evidenced by: Please refer to F279 as it relates to the failure to ensure care plans were develor meet residents' identified needs based comprehensive assessment of the individual included measurable objectives and timetables.	ped to on a duals			-
C 782	02.200,03,a,iv		C 782	Please refer to F 280	
	iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F280 as it relates to the failure to ensure care plans were review revised to reflect the current status of ear resident.	ed and			
C 784	02.200,03,b		C 784	Please refer to F 309	A STATE OF THE STA
	b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F309 as it relates to the failure to ensure care plans were followed.				
C 785	02.200,03,b,i		C 785	Please refer to F 312	
	i. Good grooming and cleanliness of body, skin, nails, hair, eyes, ears, and face, including the removal or shaving of hair in accordance with				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING_ 135090 08/02/2006

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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MARQUIS CARE AT SHAW MT		BOISE, ID 83712				
(X4) ID PREFIX TAG		SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		(X5) COMPLETE DATE		
C 785	Continued From page 12 patient/resident wishes or as necessitated to prevent infection; This Rule is not met as evidenced by: Please refer to F312 as it relates to the fact failure to ensure residents received necess assistance with grooming and personal hygo-	sary				
C 787	02.200,03,b,iii iii. Adequate fluid and nutritional intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by: Please refer to F325 as it relates to the factaillure to ensure a resident received adequinutritional intake to prevent weight loss.		Please refer to F 325			
	v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Pleas refer to F314 as it relates to the facilit failure to ensure residents did not develop pressure ulcers.	C 789	Please refer to F 314			
	02.200,03,b,xi xi. Bowel and bladder evacuation and bowel and bladder retraining programs as indicated; This Rule is not met as evidenced by: Based on observations, staff interview and medical record review, it was determined the lifty Standards.	C 795	Please refer to F 315			

Bureau of Facility Standards STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING 135090 08/02/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE ST **MARQUIS CARE AT SHAW MT BOISE, ID 83712** (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID. (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) C 795 Continued From page 13 facility did not conduct assessments of incontinence, identify risks for urinary tract infection (UTI), develop and implement care plans timely, and provide approriate during catheter, incontinence and wound care to reduce or prevent UTI. This practice affected 5 of 11 sample residents (#1,2,3,7,8) and resulted in harm to residents #1, 2, 3 and 8. Resident #2 was hospitalized with pyelonephritis on 12/14/05 and with a urinary tract infection on 2/22/06. Between February and June 2006, the resident had 2 additional urinary tract infections. Resident #1 had a history of urosepsis and was hospitalized on 5/17/06 with a urinary tract infection. From December 2005 through June 2006, resident #1 had 4 urinary tract infections. The facility did not assess, care plan or implement a procudure to establish resident #3's continence after removal of a foley catheter. Resident #8 had a supra pubic catheter in place and was at risk for UTIs. The facility did not assess resident #8 at high risk for UTI and had no documented preventative measures in place. Resident #8 was being treated for a urinary tract infection during the survey. Resident #7 had a Foley catheter in place without medical justification. Findings include: 1. Resident #2 was originally admitted to the facility on 7/31/03 and readmitted after being hospitalized for a urinary tract infection on 2/25/06 with diagnoses including Multiple Sclerosis, urinary retention, and history of urinary tract infections and pyelonephritis with stent placement. On 6/6/06, the resident had a suprapubic catheter placed. Prior to that the resident had a Foley catheter in place due to the urinary retention. The most recent MDS, dated 6/08/06,

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PRINTED: 08/16/2006

FORM APPROVED **Bureau of Facility Standards STATEMENT OF DEFICIENCIES** (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 135090 08/02/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE ST MARQUIS CARE AT SHAW MT BOISE, ID 83712 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) C 795 Continued From page 14 C 795 documented the resident was totally dependent on staff for all cares including toileting, bathing, and personal hygiene. The care plan was not dated but noted an admission date of 2/24/06 and addressed the catheter in problem 1, "ADL/Rehab." The care plan documented the resident had a suprapubic catheter and the following instructions: "suprapubic catheter. [check] site & apply [unable to read word] until healed. No! Leg Bag!" The care plan did not address the resident's history and risk for UTIs, goals, and interventions for prevention, and did not address routine catheter care. There was no information in the resident's chart regarding a care plan for Foley catheter care prior to the suprapubic insertion in June of 2006. A Resident Care Manager (RCM) was interviewed on 7/28/06 at 11:05 am regarding resident #2 and Foley catheter care. The RCM stated, "...Foley cath care was never put on the care plan..." Nursing notes from 12/05 revealed the following: *12/14/05 at 6:45 am - "Res. [resident] given Dulcolax suppository for bowel care, noted res. [with] pupils fixed & dilated, not answering questions. Moist non-productive cough. T [temperature] 99.8. DK [dark] amber, cloudy urine in BSU [bedside unit]. BS [bowel sounds] very hypoactive, abd [abdomen] firm & distended...O2 [oxygen] SAT [saturation] 82% RA [room

airl...order received to send to ER [emergency room]...order received at 4:35 am...res.

documented the resident had been admitted to a

A discharge summary dated 12/20/05

transferred at 5:00 am..."

AND PLAN	NI OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	:R/CLIA MBER:	(X2) MULTIP A. BUILDING B. WING	**************************************		LETED
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	local hospital on 12 diagnoses included status post uretera 20, 2005, for right in Nursing Notes from *2/16/06 at 11:30 at Levaquin w/repeat *2/17/06 at 2:15 am [antibiotic] for UTI - *2/20/06 @ 10:00 pt continues [without] poorly - has been hefor no apparent reas *2/21/06 at 3:30 am UTIfoley catheter [with] much white set *2/21/07 at 3:15 pm #2]. She was being cursing. Chin is quividenies being cold. Full of this were 63%. SAT per minute], [increases the relaxed SATS of to 96% on 4L. Turne [blood pressure] 132 [respirations] 24, T [Fahrenheit]. Noted Elung only. Continues	2/14/05. At discharge d'pyelonephritis, reso I stent placement Decrenal obstruction." 1 2/06 revealed the following preceived orders to UA [urinalysis] on 3/1/2 and "Continue on ABT urine dark [with] sediment" 1 - "Continue on ABT urine dark [with] sediment" 2 - "foley catheter paying with] white sediment" 3 - "Cont. [continues] A patent of clear yellow ediment" 3 - "Called to [check] [retaken to room. Yelling yering [illegible word] sed yering [illegible word] sed O2 to 3L [liters] be proped back to 68% ed O2 to 3 1/2L/min. Be 2/80, P [pulse] 119, R temperature] 101.9 [dexipirational wheezing in the sed of	living cember llowing: to start //06" ments" atent of " UTI ds taken crying lesident y & she anical vious to in [liters ut when02 up 3P egrees	C 795			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135090		ER/CLIA IMBER:	(X2) MULT A. BUILDII B. WING	***************************************	(X3) DATE SURVEY COMPLETED				
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	Continued From page *2/21/06 at 3:50 pm to [hospital] ER for each catheter of the information provided documented the residuced oxygen saturation of the information provided documented the folkow *"3/02/06- Urine poswith Zosyn changed order in one week." *"5/03/06- Started ar Urine clear amber with the physician recapidated July 2006, doc in regards to cathete *"S/P [suprapubic] catheter of the information contains are catheter of the information catheter of the informa	- "Received order to evaluation." cal, dated 2/22/06, ident was admitted to hary tract infection as urations. If by the facility on 7/3 owing: itive for enterococcusto Augmentin. Rependibiotics for UTI this ith small blood clots. itulation [RECAP] or commented the following care: ath[eter] care Q [each after the change irrigate cath [eters] GU irrigation [with a constant of the constant of t	o the nd 31/06 s treated at UA am. ders, ng orders n] shift." e 18 at [and] with] with] dressed sestion of en of	C 795					
1	o wash her hands an	id apply gloves befor	e						

Bureau of Facility Standards STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 135090 08/02/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE ST **MARQUIS CARE AT SHAW MT** BOISE, ID 83712 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **TAG** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) C 795 Continued From page 17 C 795 beginning the resident's care. The LN was observed to remove the old dressing and was not observed to change into clean gloves before continuing catheter care. Wearing contaminated gloves, the LN used a pre-moistened piece of gauze to clean around the stoma site. While cleaning around the stoma site, the LN was observed to wipe towards the stoma site with her gauze as opposed to wiping away from it. The LN used the gauze to dab around the stoma site in a circular fashion. After folding the contaminated portion of the gauze into her gloved hand, she repeated the dabbing motion with a clean portion of the same piece of gauze, again wiping towards the stoma site. When the LN had completed cleansing the site, the LN discarded the contaminated gauze and picked up the clean dressing with her contaminated glove. The LN then applied the dressing to the resident's stoma site. The LN was not observed to cleanse the catheter tubing before applying the clean dressing. According to Nursing Interventions & Clinical Skills (Elkin, Perry, Potter 2000, p. 829), when caring for a suprapubic catheter care and to prevent infection, an LN should; *"Remove old dressing and place dressing and gloves in bag." *"Put on sterile gloves, assess insertion site and patency of catheter." *Maintaining sterility, clean site by swabbing in circular motion starting closest to the catheter site and continuing in outward widening circles for approximately 2 inches (5 cm [centimeters])...' The LN is instructed to perform this step as many times as needed to cleanse the site. The authors

FORM APPROVED Bureau of Facility Standards STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 135090 08/02/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE ST MARQUIS CARE AT SHAW MT **BOISE. ID 83712** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) C 795 Continued From page 18 C 795 note this procedure "follows principle of sterile technique to move from area of least contamination to area of most contamination....Take one gauze pad moistened in antiseptic solution and cleanse catheter from proximal to distal." An interview was conducted with the DON and three RCMs on 7/27/06 at 11:55 am regarding resident #2's care plan and the prevention of UTIs. The DON noted that urinary tract infections were common in residents who were catheterized but did not address what the facility had in place regarding preventative measures for residents at risk. The DON and RCMs acknowledged the specific care plan discussed did not address the prevention of UTIs. They noted catheter care was documented on the resident's monthly treatment sheet. The facility failed to appropriately assess a resident who had a history of UTIs and pyelonephritis, identify she was at high risk for repeat UTIs and implement a care plan to prevent further infections. Facility staff failed to practice effective infection control measures during suprapubic catheter care to reduce the risk of infection. At the time of the survey, the facility had no measures in place to prevent urinary tract infections. 2. Resident # 1 was originally admitted to the facility on 10/19/05 and most recently readmitted on 5/23/06 with diagnoses including Quadriplegia,

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neurogenic bladder.

decubitus ulcer, osteomyelitis, pancytopenia, cirrhosis, diabetes mellitus 2, Methicillin Resistant Staphylococcus Aureus [MRSA], depression. chronic anemia, and chronic leukopenia. The resident had a suprapubic catheter due to a

Bureau of Facility Standards STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 135090 08/02/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE ST MARQUIS CARE AT SHAW MT **BOISE, ID 83712** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) C 795 Continued From page 19 C 795 The most recent MDS, dated 6/5/06, documented the resident was totally dependent on staff for bathing, toileting, and personal hygiene. The care plan, dated 5/23/06, addressed the catheter in problem 1, "ADL/Rehab." The care plan documented the resident had a suprapubic catheter and the size of the catheter and the balloon. The care plan did not address the resident's risk for UTI, goals, and interventions for prevention, and did not address catheter care. The physician RECAP orders, dated July 2006. documented the following orders in regards to the resident's catheter: *5/23/06 "Supra Pubic Cath[eter] care q [every] shift DX [diagnosis]: Neurogenic bladder." *5/23/06 "Change Supra Pubic Cath Q month 20 French w/30 cc balloon." The treatment sheet, dated July 2006, documented "Super [sic] Pubic Cath Care Q Shift" and "Change Super [sic] Pubic Q Month 20 French W/30 CC Balloon." Information provided by the facility on 7/31/06 revealed the following history related to urinary tract infections: *10/19/05 The resident was admitted to the facility following hospitalization for urosepsis. Prior to the hospitalization, the resident had been living at home. *12/07/05 Temperature of 100 [degrees Fahrenheit], bloody drainage from suprapubic catheter. Started on Macrobid and urinalysis (UA)

Bureau of Facility Standards **STATEMENT OF DEFICIENCIES** (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 135090 08/02/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE ST MARQUIS CARE AT SHAW MT **BOISE, ID 83712** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) C 795 Continued From page 20 C 795 with culture and sensitivity obtained. The results revealed Escherichia coli (E-coli). *12/22/05 UA obtained due to "SP [suprapubic] trauma with increased temp..." The results revealed Pseudomonas Aeruginosa. *3/9/06 "H & P [history and physical] states urine appears infected with specific gravity > Igreater than 1030, 1+ proteinuria, trace ketones, 3+ occult blood, 3+ leukocyte esterase, + nitrites, 5-10 RBC's [red blood cells], 25-50 WBC [white blood cells], many bacteria, moderate yeast. Impression: Acute sepsis...suspect early sepsis. either from leg wound or from UTI." A physician's note, dated 6/23/06, revealed the resident, "was hospitalized on 5/17/06-5/23/06 for a urinary tract infection with candida albicans." The resident was observed during wound and peri care on 7/25/06 at approximately 11:10 am. The LN washed her hands and donned gloves before cleaning and covering the stage II pressure ulcer on the resident's right ischium. The LN was not observed to wash or sanitize her hands or change her gloves before proceeding to care for the stage IV pressure ulcer on the resident's left ischium. According to documentation, the resident had recently been on isolation precautions due to MRSA infection in the stage IV pressure ulcer. The LN cleansed and covered the wound. During the procedure, she reached into her pocket with her contaminated gloves to pull out a pair of scissors and a sharpie pen. The LN was observed to place the sharple back into her pocket handling it with her contaminated gloves. After completing wound care, the LN proceeded to assist the CNA in repositioning the resident. The resident had a

Bureau of Facility Standards STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION **AND PLAN OF CORRECTION** IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 135090 08/02/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE ST MARQUIS CARE AT SHAW MT BOISE, ID 83712 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) C 795 Continued From page 21 C 795 bowel movement and required clean up and peri care. The LN was not observed to wash or sanitize her hands after the wound care and before getting herself and the CNA a clean pair of gloves before they began the peri care. During the procedure, a large amount of feces came into contact with the top cover of the resident's air bed. The CNA and LN wiped the area and noted they would change the cover after getting the resident up for lunch in about an hour or so. After completing peri care and dressing the resident in clean clothing, staff were observed to place the resident directly on top of the contaminated area of the air bed with his clean clothing in direct contact with the contaminated surface. An interview was conducted with the DON and three RCMs on 7/27/06 at 11:55 am regarding resident #1 and #2's care plans and the prevention of UTIs. As stated above, the DON noted that urinary tract infections were common in residents who were catheterized but did not address what the facility had in place regarding prevention measures for residents at risk. The DON and RCMs acknowledged the specific care plans discussed did not address the prevention of UTIs. They noted catheter care was documented on the residents' monthly treatment sheet. When questioned as to what preventative measures the facility was taking to UTIs for resident #1, staff stated they used a leg bag on the resident at times to prevent the catheter tubing from touching the floor and becoming contaminated as well as following facility protocol for suprapubic catheter care. After the interview was concluded, a RCM presented the surveyor with an undated handwritten list that contained the following information: Vitamin C 500 milligrams twice a day, Suprapubic catheter care every shift, using leg bag for catheter when resident is out of bed.

Bureau of Facility Standards **STATEMENT OF DEFICIENCIES** (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION **AND PLAN OF CORRECTION** IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 135090 08/02/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE ST MARQUIS CARE AT SHAW MT **BOISE, ID 83712** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY C 795 Continued From page 22 C 795 and Minocin 100 milligrams twice a day. According to the resident's physician RECAP. dated July 2006, the resident had been prescribed Minocin on 5/23/06 due to the MRSA infection in his pressure ulcer. The facility failed to appropriately assess a resident who had a history of UTIs and urosepsis. identify he was at high risk for repeat UTIs and implement a care plan to prevent further infections. Facility staff practiced poor infection control during wound and peri care on a resident with known MRSA infection. This failed practice resulted in harm to the resident who was hospitalized in May 2006 with a urinary tract infection. At the time of the survey, the facility had no measures in place to prevent urinary tract infections. Resident #8 was originally admitted to the facility on 1/26/1995, and readmitted on 3/25/04, with diagnoses including paraplegia, schizophrenia, neurogenic bladder, UTI, status post venous thrombosis and cellulitis of the buttocks. The most recent quarterly assessment, dated 5/26/06, documented the resident had severely impaired cognition, was totally dependent for all care and had a suprapuble catheter in place. The care plan, dated 3/25/04, addressed the catheter in problem 1, "ADL/Rehab." The care plan documented the resident had a suprapubic catheter and the size of the catheter and the balloon. The care plan did not address the resident's risk for UTI, goals, and interventions for prevention, and did not address catheter care. The physician's RECAP, dated July 2006,

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FORM APPROVED Bureau of Facility Standards STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 135090 08/02/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE ST MARQUIS CARE AT SHAW MT BOISE, ID 83712 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX COMPLETE (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) C 795 Continued From page 24 C 795 catheterized or noncatherized individual should lead the facility to check whether perineal hygiene is performed consistently to remove fecal soiling in accordance with accepted practices...to re-evaluate the techniques being used for perineal hygiene and catheter care...the facility should demonstrate that they: Employ standard infection control practices in managing catheters and associated drainage system; Strive to keep the resident and catheter clean of feces to minimize bacterial migration into the urethra and bladder...; Assess for fluid needs and implement a fluid management program...based on those assessed needs." The facility failed to identify residents at risk for UTIs, develop care plans addressing preventative measures and demonstrate appropriate infection control practices during wound and catheter care. 4. Resident #3 was admitted on 4/28/06 with diagnoses which included CVA [stroke] hematoma of left leg, sacral stenosis, and dementia. At the time of admission, the resident had a Foley catheter in place. The catheter was discontinued on 5/1/06 per documentation in nursing notes. An MDS, dated 5/9/06, documented the resident was severely impaired in cognition, was totally dependent on staff for most ADLs including toilet use and that she was frequently incontinent of urine.

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An "Assessment for Bowel & Bladder Training" dated 4/28/06, documented the following in the "Bladder Continence Pattern" section: "N/A [not applicable]" and the box "Frequently incontinent (daily with some control)" was marked. The form noted the resident had a Foley catheter that had

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everyone, they wouldn't have time for other cares.

The facility did not ensure a resident was

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A transfer physician order dated 7/13/06 documented, "Discontinue Foley per [physician

Resident #7's current care plan documented that the resident had a commode at his bedside.

name] at follow-up appointment..."

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	(X5) COMPLETE DATE	
C 795	Continued From pa	ge 27		C 795			
	On 7/27/06 at 3:15 interviewed. He indihead and his hands commode for bowel On 7/26/06 at 9:05 resident #7 was adrand and was not su would find out and let	e resident used the tang. pm, resident #7 was cated with the motion that he used his bed movements. am, the DON indicate mitted with a Foley care why it was in place of the surveyor know a provided the surveyor	n of his I side ed that atheter e but . Several				
And the second s	documented, "Foley	one order dated 7/26 catheter indicated r/ spiratory distress [with	t [related				
THE PARTY OF THE P	and there was no do medical condition th use of an indwelling ensure that a reside	mitted with a Foley concumentation indicating at warranted the concatheter. The facility nt with a catheter wated to determine the	ng any tinued failed to s		·		
C 881	individual medical re maintained for each entries kept current, signed. All records s typewritten or record ink, and shall contain This Rule is not me	ical Record. An ecord shall be admission with all dated and hall be either led legibly in n the following:		C 881	Please refer to F 514		

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